

VS A15 (4)  
15M 9/55

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN		19. SIGNATURE OF CLERGYMAN		20. SIGNATURE OF JUDGE		21. SIGNATURE OF JURY		22. SIGNATURE OF JUDGE		23. SIGNATURE OF JURY		24. SIGNATURE OF JUDGE	
25. SIGNATURE OF JURY		26. SIGNATURE OF JUDGE		27. SIGNATURE OF JURY		28. SIGNATURE OF JUDGE		29. SIGNATURE OF JURY		30. SIGNATURE OF JUDGE		31. SIGNATURE OF JURY		32. SIGNATURE OF JUDGE	
33. SIGNATURE OF JURY		34. SIGNATURE OF JUDGE		35. SIGNATURE OF JURY		36. SIGNATURE OF JUDGE		37. SIGNATURE OF JURY		38. SIGNATURE OF JUDGE		39. SIGNATURE OF JURY		40. SIGNATURE OF JUDGE	
41. SIGNATURE OF JURY		42. SIGNATURE OF JUDGE		43. SIGNATURE OF JURY		44. SIGNATURE OF JUDGE		45. SIGNATURE OF JURY		46. SIGNATURE OF JUDGE		47. SIGNATURE OF JURY		48. SIGNATURE OF JUDGE	
49. SIGNATURE OF JURY		50. SIGNATURE OF JUDGE		51. SIGNATURE OF JURY		52. SIGNATURE OF JUDGE		53. SIGNATURE OF JURY		54. SIGNATURE OF JUDGE		55. SIGNATURE OF JURY		56. SIGNATURE OF JUDGE	
57. SIGNATURE OF JURY		58. SIGNATURE OF JUDGE		59. SIGNATURE OF JURY		60. SIGNATURE OF JUDGE		61. SIGNATURE OF JURY		62. SIGNATURE OF JUDGE		63. SIGNATURE OF JURY		64. SIGNATURE OF JUDGE	
65. SIGNATURE OF JURY		66. SIGNATURE OF JUDGE		67. SIGNATURE OF JURY		68. SIGNATURE OF JUDGE		69. SIGNATURE OF JURY		70. SIGNATURE OF JUDGE		71. SIGNATURE OF JURY		72. SIGNATURE OF JUDGE	
73. SIGNATURE OF JURY		74. SIGNATURE OF JUDGE		75. SIGNATURE OF JURY		76. SIGNATURE OF JUDGE		77. SIGNATURE OF JURY		78. SIGNATURE OF JUDGE		79. SIGNATURE OF JURY		80. SIGNATURE OF JUDGE	
81. SIGNATURE OF JURY		82. SIGNATURE OF JUDGE		83. SIGNATURE OF JURY		84. SIGNATURE OF JUDGE		85. SIGNATURE OF JURY		86. SIGNATURE OF JUDGE		87. SIGNATURE OF JURY		88. SIGNATURE OF JUDGE	
89. SIGNATURE OF JURY		90. SIGNATURE OF JUDGE		91. SIGNATURE OF JURY		92. SIGNATURE OF JUDGE		93. SIGNATURE OF JURY		94. SIGNATURE OF JUDGE		95. SIGNATURE OF JURY		96. SIGNATURE OF JUDGE	
97. SIGNATURE OF JURY		98. SIGNATURE OF JUDGE		99. SIGNATURE OF JURY		100. SIGNATURE OF JUDGE		101. SIGNATURE OF JURY		102. SIGNATURE OF JUDGE		103. SIGNATURE OF JURY		104. SIGNATURE OF JUDGE	
105. SIGNATURE OF JURY		106. SIGNATURE OF JUDGE		107. SIGNATURE OF JURY		108. SIGNATURE OF JUDGE		109. SIGNATURE OF JURY		110. SIGNATURE OF JUDGE		111. SIGNATURE OF JURY		112. SIGNATURE OF JUDGE	
113. SIGNATURE OF JURY		114. SIGNATURE OF JUDGE		115. SIGNATURE OF JURY		116. SIGNATURE OF JUDGE		117. SIGNATURE OF JURY		118. SIGNATURE OF JUDGE		119. SIGNATURE OF JURY		120. SIGNATURE OF JUDGE	
121. SIGNATURE OF JURY		122. SIGNATURE OF JUDGE		123. SIGNATURE OF JURY		124. SIGNATURE OF JUDGE		125. SIGNATURE OF JURY		126. SIGNATURE OF JUDGE		127. SIGNATURE OF JURY		128. SIGNATURE OF JUDGE	
129. SIGNATURE OF JURY		130. SIGNATURE OF JUDGE		131. SIGNATURE OF JURY		132. SIGNATURE OF JUDGE		133. SIGNATURE OF JURY		134. SIGNATURE OF JUDGE		135. SIGNATURE OF JURY		136. SIGNATURE OF JUDGE	
137. SIGNATURE OF JURY		138. SIGNATURE OF JUDGE		139. SIGNATURE OF JURY		140. SIGNATURE OF JUDGE		141. SIGNATURE OF JURY		142. SIGNATURE OF JUDGE		143. SIGNATURE OF JURY		144. SIGNATURE OF JUDGE	
145. SIGNATURE OF JURY		146. SIGNATURE OF JUDGE		147. SIGNATURE OF JURY		148. SIGNATURE OF JUDGE		149. SIGNATURE OF JURY		150. SIGNATURE OF JUDGE		151. SIGNATURE OF JURY		152. SIGNATURE OF JUDGE	
153. SIGNATURE OF JURY		154. SIGNATURE OF JUDGE		155. SIGNATURE OF JURY		156. SIGNATURE OF JUDGE		157. SIGNATURE OF JURY		158. SIGNATURE OF JUDGE		159. SIGNATURE OF JURY		160. SIGNATURE OF JUDGE	
161. SIGNATURE OF JURY		162. SIGNATURE OF JUDGE		163. SIGNATURE OF JURY		164. SIGNATURE OF JUDGE		165. SIGNATURE OF JURY		166. SIGNATURE OF JUDGE		167. SIGNATURE OF JURY		168. SIGNATURE OF JUDGE	
169. SIGNATURE OF JURY		170. SIGNATURE OF JUDGE		171. SIGNATURE OF JURY		172. SIGNATURE OF JUDGE		173. SIGNATURE OF JURY		174. SIGNATURE OF JUDGE		175. SIGNATURE OF JURY		176. SIGNATURE OF JUDGE	
177. SIGNATURE OF JURY		178. SIGNATURE OF JUDGE		179. SIGNATURE OF JURY		180. SIGNATURE OF JUDGE		181. SIGNATURE OF JURY		182. SIGNATURE OF JUDGE		183. SIGNATURE OF JURY		184. SIGNATURE OF JUDGE	
185. SIGNATURE OF JURY		186. SIGNATURE OF JUDGE		187. SIGNATURE OF JURY		188. SIGNATURE OF JUDGE		189. SIGNATURE OF JURY		190. SIGNATURE OF JUDGE		191. SIGNATURE OF JURY		192. SIGNATURE OF JUDGE	
193. SIGNATURE OF JURY		194. SIGNATURE OF JUDGE		195. SIGNATURE OF JURY		196. SIGNATURE OF JUDGE		197. SIGNATURE OF JURY		198. SIGNATURE OF JUDGE		199. SIGNATURE OF JURY		200. SIGNATURE OF JUDGE	

BUREAU V. S.

FEB 21 1959

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1473

CERTIFICATE OF DEATH

01433

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8 Wellham Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Albert</u> Last <u>Andrews</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 15 1885</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elevator Repairs</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Bethlehem Md.</u>	
13. FATHER'S NAME <u>George E Andrews</u>		14. MOTHER'S MAIDEN NAME <u>Mary E Valliant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-32-6034</u>	
17. INFORMANT <u>Mary R. Andrews</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X Cancer of Lung -</u> DUE TO (b) <u>Bronchitis -</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>Diabetes</u> DUE TO (c) <u>Diabetes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs -</u> <u>10-15 yrs</u> <u>2 yrs -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/18/58</u> , 19 <u>58</u> , to <u>2/18/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/18/58</u> , 19 <u>58</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Linthicum</u> DATE SIGNED <u>2/18/58</u>	
PHYSICIAN'S NAME (Type) <u>William Cook, Inc., 1217 St. Paul Street</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-22-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Governor Ritchie Highway</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>FEB 21 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Deedman</u>			

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TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1439

## CERTIFICATE OF DEATH

01434

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gambrills</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>M</b> Middle <b>BURCH</b> Last <b>BEARD</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>21</b> Year <b>19 58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 6, 1885</b>	
9. AGE (In years lost birthday) <b>72</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tabacco</b>		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Julian M. Beard</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Phelps</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> <b>No</b>		16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Mrs Margaret Beard- Wife- same as # 2</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cobor pneumonia</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>myocardial Insufficiency</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>490x</b>				INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 20, 1958</b> , to <b>Feb 21</b> , 1958, that I last saw the deceased alive on <b>Feb. 21</b> , 1958, and that death occurred at <b>3:15 A. M.</b> from the causes and on the date stated above.				
ACTUAL SIGNATURE <b>Emily H. Wilson, M.D.</b> M.D.		ADDRESS (Street, city or town, state) <b>Lothian, Maryland</b> DATE SIGNED <b>2-22-58</b>		
PHYSICIAN'S NAME (Type) <b>Emily Wilson, M.D.</b>		<b>Lothian, Maryland</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 23, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Davidsonville Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Davidsonville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>		ADDRESS <b>Annapolis, Md.</b>		
24a. REC'D BY REGISTRAR DATE <b>FEB 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>		

CERTIFICATE OF DEATH

1933

FILE NO. 10

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, place of death, cause of death, and physician's signature.

BUREAU V. S.

FEB 25 1933

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## CERTIFICATE OF DEATH

01435

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY <b>Washington, D.C.</b> 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Laurel</b>		c. LENGTH OF STAY IN lb <b>1 month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>District Training Sch., Children's Center</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Michel Henry Bomar</b>		4. DATE OF DEATH Month Day Year <b>February 18, 1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22, 1956</b>
9. AGE (In years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lucius Bomar</b>		14. MOTHER'S MAIDEN NAME <b>Celia Fox Bomar</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT <b>Children's Center</b>		Address <b>Laurel, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aspiration</b> DUE TO (c) <b>Congenital Hydrocephalus</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental retardation</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) --		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. -- 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --	20f. (City or town) (County) (State) --
21. I certify that I attended the deceased from <b>Jan. 17, 1958</b> , to <b>Feb. 18, 1958</b> , that I last saw the deceased alive on <b>Feb. 18, 1958</b> , and that death occurred at <b>5:40 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wilfred R. Ehrmantraut</i> M.D.		ADDRESS (Street, city or town, state) <b>Children's Center, Laurel, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Wilfred R. Ehrmantraut, M.D.</b>		DATE SIGNED <b>2/19/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-21-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>DTS Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Laurel, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Thomas</i>		ADDRESS <b>D.T. J. Thomas, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE FEB 24 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Overman</i>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of Two

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BURKAY V. L.

FEB 24 1958

RECEIVED

1475  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Odenton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Odenton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington + Pine</i>		d. STREET ADDRESS <i>Washington + Pine</i>	
3. NAME OF DECEASED (Type or print) First <i>Lucy</i> Middle <i>C.</i> Last <i>Brady</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>7</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 1, 1869</i>
9. AGE (In years last birthday) <i>88</i> yrs.		IF UNDER 1 YEAR: Months <i>88</i> Days <i>88</i> Hours <i>88</i> Min. <i>88</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Calvert Co. Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>William Smith</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT <i>Mrs. Iva C. Stallings</i> Address <i>#2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Acute Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) <i>---</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>---</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>---</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>---</i> p. m. <i>---</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>---</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb 6-58</i> to <i>Feb 7-58</i> , that I last saw the deceased alive on <i>Feb 6-58</i> , 19 <i>58</i> , and that death occurred at <i>3A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph Lipskey</i> M.D.		ADDRESS (Street, city or town, state) <i>Annapolis Md</i>	
PHYSICIAN'S NAME (Type) <i>DR. JOSEPH LIPSKEY</i>		DATE SIGNED <i>Feb 7-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-9-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Hollywood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i> ADDRESS <i>Annapolis Md</i>		24a. REC'D BY REGISTRAR <i>Feb 10 58</i>	24b. REGISTRAR'S SIGNATURE <i>W. S. Smith</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 1476 CERTIFICATE OF DEATH

Reg. Dist. No.

01437

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Raynor Heights</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Raynor Heights</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Nursery Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Helen May Bremer</b>		4. DATE OF DEATH <b>Feb. 20, 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1884</b>
9. AGE (In years from birthday) <b>73</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None c</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Edward Bremer</b>		Address <b>Same</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Vascular Disease</b> <b>241X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchial asthma</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 yrs.</b> <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>1936</b> to <b>2/20</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/20/58</b> , 19 <b>58</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.		
ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE <b>Chas. L. Ball Jr.</b> M.D.		<b>203 W. Maple Road Feb. 21, 1958</b>
PHYSICIAN'S NAME (Type) <b>Charles L. Ball Jr. M.D.</b> <b>Linthicum, A. A. Co., Md.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 22, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>
22d. LOCATION (City, town, or county) (State) <b>Ritchie Hgwy. A. A. Co., Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>4001 Ritchie Hgwy.</b>		24a. REC'D BY REGISTRAR <b>FEB 25 58</b>
24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>		

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1440

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St Margarets</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. A. General Hospt</i>		d. STREET ADDRESS <i>Annapolis P. &amp; D</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>Hoffman</i> Last <i>Brice</i>		4. DATE OF DEATH Month <i>2</i> Day <i>14</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Aug 15-1906</i>
9. AGE (In years last birthday) <i>51</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk (Ret)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>	11. BIRTHPLACE (State or foreign country) <i>St Margarets Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>L. Carroll Brice</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Lydings</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Carlton Waring</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Liverne's Cirrhosis</i> 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hemorrhagic pancreaticitis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i> ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4-5-1</i> , 19 <i>58</i> , to <i>2-14-</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>2-13-58</i> , 19 <i>58</i> , and that death occurred at <i>7:20 PM</i> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <i>63 College Ave</i>		DATE SIGNED <i>2-14-58</i>	
ACTUAL SIGNATURE <i>Frank M Shipley</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i>		<i>Annapolis Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-16-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md</i>	24a. REC'D BY REGISTRAR DATE <i>FEB 19 '58</i>
		24b. REGISTRAR'S SIGNATURE <i>Redman</i>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH _____		MARRIAGE _____	
PLACE OF BIRTH _____		PLACE OF BIRTH _____	
DATE OF BIRTH _____		DATE OF BIRTH _____	
SEX _____		SEX _____	
RACE _____		RACE _____	
OCCUPATION _____		OCCUPATION _____	
CAUSE OF DEATH _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF DEATH REGISTRAR _____		SIGNATURE OF DEATH REGISTRAR _____	
DATE _____		DATE _____	

BUREAU V. S.  
FEB 19 1933

RECEIVED



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G226 3-13-58 et

1441

CERTIFICATE OF DEATH

Reg. Dist. No.

01439

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY in 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>L.</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 30, 1893</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Chesterfield, A.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Brown</u>		14. MOTHER'S MAIDEN NAME <u>Martha Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Olda. Brown</u>		Address <u>Annapolis</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Arteriosclerotic Hypertension</u> (c) <u>Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 25, 1958</u> to <u>Feb 28, 1958</u> , that I last saw the deceased alive on <u>Feb 28, 1958</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Richardson</u>		ADDRESS (Street, city or town, state) <u>110-CLAY ST, ANNAPOLIS, MD</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <u>3/3/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Mar 4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Johnson</u>		ADDRESS <u>Annapolis</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>MAR 5 '58</u>			

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 1442

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>W.D. General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Daniel</u> First <u>Brown</u> Middle <u>Brown</u> Last				4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-20-1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip Brown</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-28-3192</u>		17. INFORMANT <u>Catherine Horsey</u> Address <u>2309 Whittier Ave. Baltimore</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Anger's Tailor</u> <u>795.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>2-22-58</u> , 19 <u>58</u> , to <u>2-27-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-27-58</u> , 19 <u>58</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. T. Allen</u>				ADDRESS (Street, city or town, state) <u>62 Cathedral</u> DATE SIGNED <u>2-27-58</u>			
PHYSICIAN'S NAME (Type) <u>A T A L L E N</u>				<u>Annapolis, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-3-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chenoweth Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Owensville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> ADDRESS <u>108 Wash St. Annapolis, Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. RACE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. DATE OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF REGISTRAR	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESS		13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESS	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESS		23. SIGNATURE OF DECEASED		24. SIGNATURE OF WITNESS		25. SIGNATURE OF DECEASED	
26. SIGNATURE OF WITNESS		27. SIGNATURE OF DECEASED		28. SIGNATURE OF WITNESS		29. SIGNATURE OF DECEASED		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESS		33. SIGNATURE OF DECEASED		34. SIGNATURE OF WITNESS		35. SIGNATURE OF DECEASED	
36. SIGNATURE OF WITNESS		37. SIGNATURE OF DECEASED		38. SIGNATURE OF WITNESS		39. SIGNATURE OF DECEASED		40. SIGNATURE OF WITNESS	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF WITNESS		43. SIGNATURE OF DECEASED		44. SIGNATURE OF WITNESS		45. SIGNATURE OF DECEASED	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF DECEASED		48. SIGNATURE OF WITNESS		49. SIGNATURE OF DECEASED		50. SIGNATURE OF WITNESS	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF WITNESS		53. SIGNATURE OF DECEASED		54. SIGNATURE OF WITNESS		55. SIGNATURE OF DECEASED	
56. SIGNATURE OF WITNESS		57. SIGNATURE OF DECEASED		58. SIGNATURE OF WITNESS		59. SIGNATURE OF DECEASED		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESS		63. SIGNATURE OF DECEASED		64. SIGNATURE OF WITNESS		65. SIGNATURE OF DECEASED	
66. SIGNATURE OF WITNESS		67. SIGNATURE OF DECEASED		68. SIGNATURE OF WITNESS		69. SIGNATURE OF DECEASED		70. SIGNATURE OF WITNESS	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF WITNESS		73. SIGNATURE OF DECEASED		74. SIGNATURE OF WITNESS		75. SIGNATURE OF DECEASED	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF DECEASED		78. SIGNATURE OF WITNESS		79. SIGNATURE OF DECEASED		80. SIGNATURE OF WITNESS	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF WITNESS		83. SIGNATURE OF DECEASED		84. SIGNATURE OF WITNESS		85. SIGNATURE OF DECEASED	
86. SIGNATURE OF WITNESS		87. SIGNATURE OF DECEASED		88. SIGNATURE OF WITNESS		89. SIGNATURE OF DECEASED		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESS		93. SIGNATURE OF DECEASED		94. SIGNATURE OF WITNESS		95. SIGNATURE OF DECEASED	
96. SIGNATURE OF WITNESS		97. SIGNATURE OF DECEASED		98. SIGNATURE OF WITNESS		99. SIGNATURE OF DECEASED		100. SIGNATURE OF WITNESS	

BUREAU V. E.

MAR 3 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01441

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena, Rural Route</u> c. LENGTH OF STAY IN 1b <u>Over 15 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Light Street &amp; Pasadena Rd.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry E. Burch (Harry E. Burck, Jr.)</u>		4. DATE OF DEATH Month Day Year <u>February 13th. 19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/15/92</u>
9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Railroad Man., Machinist B &amp; O Balto., Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Harry E. Burch Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Lucil Western Hayes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-05-3389</u>	
17. INFORMANT <u>Mr. Georges F. Hayes (Foster brother)</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/13/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mon Feb 17 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem., Woodlawn, Balto. Co., Md.</u>		22d. LOCATION (City, town or county) (State) <u>Balto. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Howard Evans</u>		24a. REC'D BY REGISTRAR <u>FEB 18 '58</u> 24b. REGISTRAR'S SIGNATURE <u>G. Howard Evans</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

FEB 18 1952

BUREAU V. S.

STATE OF  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1

1478

1478

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01442

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u> <u>25ys, 3 mos.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>340114</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>				d. STREET ADDRESS <u>825 N. Gilmore Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle _____ Last <u>Cephus</u>				4. DATE OF DEATH Month <u>2</u> Day <u>16</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/25/76</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>James Cephus</u>				14. MOTHER'S MAIDEN NAME <u>Martha Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>December 21, 1957</u> , to <u>February 16, 1958</u> , that I last saw the deceased alive on <u>February 16, 1958</u> , and that death occurred at <u>5:10 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>				ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>2/19/58</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>				<u>Crownsville State Hospital, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>2/27/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Ann's</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Bennett</u>				ADDRESS <u>1084 Wash. St. Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 4 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>							

TO HOSPITAL OR TO FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 1, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, place of death, cause of death, and physician's signature. The form is mostly blank with some faint markings.

BUREAU V. 1

MAR 4 1958

RECEIVED



CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is oriented horizontally but contains vertical text labels for various categories.

BUREAU V. 2

FEB 18 1938

RECEIVED



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01444

## 1480 CERTIFICATE OF DEATH

Item 7 FilmG225 2-7-58 et

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>ANNE ARUNDEL</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u> LENGTH OF STAY (in this place) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR CONV. HOME</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>C.A.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>10</u> TOWN <u>Annapolis</u> STREET ADDRESS <u>13 Monument St.</u> (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>JOSEPHINE</u> (First) <u>COATES</u> (Middle) (Last) 5. SEX <u>F</u> 6. COLOR OR RACE <u>C</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> 8. DATE OF BIRTH <u>1-29-1892</u> 9. AGE last birthday <u>76</u> yrs.		4. DATE OF DEATH <u>Feb 2</u> 19 <u>58</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Smothers</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Smothers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT & ADDRESS <u>Richard David Anna, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) <u>Cerebrovascular accident</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis general</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1953</u> , to <u>Feb 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 30</u> , 19 <u>58</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Joseph Taler</u> ADDRESS (Street, city, town, state) <u>102 Bx A Blvd. N.E. Glen Burnie, Md.</u> DATE SIGNED <u>2-2-58</u> M.D. <u>102 Bx A Blvd. N.E. Glen Burnie, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>2-7-58</u> NAME OF CEMETERY OR CREMATORY <u>Frederick Hill</u> LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>			
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <u>William Reese, Jr. - Anna, Md.</u> 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
DATE <u>FEB 4 1958</u>			

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. DEATH CERTIFICATE (Faint text)

2. STATE CERTIFICATE (Faint text)

3. DEATH CERTIFICATE (Faint text)

MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BOSTON, MASS.

4. STATE CERTIFICATE (Faint text)

5. DEATH CERTIFICATE (Faint text)

6. STATE CERTIFICATE (Faint text)

7. DEATH CERTIFICATE (Faint text)

8. DEATH CERTIFICATE (Faint text)

9. DEATH CERTIFICATE (Faint text)

10. DEATH CERTIFICATE (Faint text)

11. DEATH CERTIFICATE (Faint text)

12. DEATH CERTIFICATE (Faint text)

13. DEATH CERTIFICATE (Faint text)

RECEIVED

BUREAU V. S.

EB 4 1938

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital must retain a copy of the certificate.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

01445

Reg. Dist. No. ....

1481

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Glen Burnie</u>		<u>2 yrs</u>		TOWN <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>207 Ritchie Highway.</u>				STREET ADDRESS (If rural give location) <u>207 Ritchie Highway</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>Jane</u> (Last) <u>Crane</u>				(Month) <u>2</u> (Day) <u>8</u> (Year) <u>19 58</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>1/19/1879</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>house work</u>		<u>at home</u>		<u>Wofford Ireland</u>		<u>U.S.A</u>	
13. FATHER'S NAME <u>William Boyse</u>				14. MOTHER'S MAIDEN NAME <u>Budget Kinselle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mr William J. Crane</u> <u>201 St McCurley</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A) <u>Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Nephro-sclerosis</u>				<u>9</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive Arteriosclerotic Heart Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 5</u> , 19 <u>58</u> , to <u>Feb</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-7</u> , 19 <u>58</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles R. MacDonald MD</u>				ADDRESS (Street, city, town, state) <u>P.O. Box 518 Glen Burnie</u> DATE SIGNED <u>2-8-58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/12/58</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd. Glen Burnie Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John J. Cowan</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u>		ADDRESS <u>90 E. 1st St</u>	
DATE <u>FEB 1 0 '58</u>							

# CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

BUREAU V. S.

FEB 10 1953

RECEIVED

25001075241

Form

01446

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RALPH</u> <u>DAVIS</u>		4. DATE OF DEATH Month Day Year <u>February 6</u> <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1898</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralph Davis, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Estes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mrs. Mary Davis,</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>Coronary insufficiency</u> DUE TO <u>Arteriosclerotic Cardio-vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>3 months</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1953</u> , to <u>February 6, 1958</u> , that I last saw the deceased alive on <u>February 5, 1958</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>		DATE SIGNED <u>February 6, 1958</u>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 10/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Maplewood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Gordonsville, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Smyth</u>		24a. REC'D BY REGISTRAR <u>Feb 10 1958</u>	
ADDRESS <u>Glen Burnie, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>R. V. Smyth</u>	

## MEDICAL CERTIFICATION



# CERTIFICATE OF DEATH

BUREAU V. S.

FEB 10 1963

RECEIVED

14822497-CE

CERTIFICATE OF DEATH

01447

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Route 2 - Glen Burnie about 5 mi</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie P.O., Pt. Pleasant</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Furnace Drive Box 169A</u>				d. STREET ADDRESS <u>Furnace Dr.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>LENA</u> Middle <u>Den</u> Last <u>ig</u>				4. DATE OF DEATH <u>SUN., FEB. 9, 1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 2, 1878</u>	
9. AGE (in years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR <u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min.		IF UNDER 24 HRS. <u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT-Home</u>		11. BIRTHPLACE (State or foreign country) <u>WISCONSIN</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>(P) POTEN</u>				14. MOTHER'S MAIDEN NAME <u>(P)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>JOHN J. ARMSTRONG - (SAME)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Lung - 163x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension &amp; Arterio-sclerosis</u> DUE TO (c) <u>10 yrs -</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct. 10, 1957</u> to <u>Feb. 9, 1958</u> , that I last saw the deceased alive on <u>Feb. 9, 1958</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas - L - Ball Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Linthicum, Md.</u> DATE SIGNED <u>2/10/58</u>			
PHYSICIAN'S NAME (Type) <u>Chas. L. Ball, Jr.</u>				Linthicum, Md. <u>2/10/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Feb. 13, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LODI-Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>LODI, New York (Seneca Co)</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard Evans</u> ADDRESS <u>14005 CHARLES ST. BALT</u>				24a. REC'D BY REGISTRAR <u>FEB 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 1

FEB 11 1959

RECEIVED

may be retained by the funeral director, by the funeral director, and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, the page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, the page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

# MD STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 226 3-6-58ams Item 16 FilmG226 2-28-58 et

1483

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

01448

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft. George G. Meade</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>Ft. George G. Meade</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Army Hospital</b>				d. STREET ADDRESS <b>4303 Roberts Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JEFFERSON</b> Middle <b>R</b> Last <b>DENNIS</b>				4. DATE OF DEATH Month <b>February</b> Day <b>17</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 April 1909</b>		9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months <b>48</b> Days <b>48</b> Hours <b>48</b> Min.	IF UNDER 24 HRS. Months <b>48</b> Days <b>48</b> Hours <b>48</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Professional Navy Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Colorado</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank L. Dennis</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Rice</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>551-34-3791</b>		17. INFORMANT <b>Hospital and personnel Records</b> <b>Ft. George G. Meade, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of stomach contents</b> DUE TO <b>Acute coronary insufficiency, with</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Pulmonary edema</b> DUE TO <b>Coronary artery spasm</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Less than 20 minutes</b> <b>30 minutes</b> <b>30 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>17 February, 19 58</b> , to <b>17 February 19 58</b> , that I last saw the deceased alive on <b>Dead when first examined</b> , and that death occurred at <b>1140A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city, or town, state) <b>U. S. ARMY HOSPITAL, FT MEADE, MD</b> DATE SIGNED <b>17 Feb 58</b>							
ACTUAL SIGNATURE <b>Julian T Harwell</b>		M.D. <b>U. S. ARMY HOSPITAL, FT MEADE, MD</b>					
PHYSICIAN'S NAME (Type) <b>JULIAN T HARWELL, CAPT</b>		U. S. ARMY HOSPITAL, FT MEADE, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/21/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Carl B. Webster</b>				ADDRESS <b>Funeral Home, Inc.</b>		24a. REC'D BY REGISTRAR DATE <b>17 Feb 58</b>	
						24b. REGISTRAR'S SIGNATURE <b>CLAUDE D LAUSTIER</b>	

6304 - Belair Rd - Baltimore - 6 - Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

RECEIVED

FEB 24 1958

BUREAU V. 8



1484  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD-</u> b. COUNTY <u>ANNE ARUNDEL.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAMBRILLS MD.</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>GAMBRILLS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>				1. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>DUNCAN</u> Last <u>DUNCAN</u>				4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1958.</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-9-1891</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Boston Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lake Duncan</u>				14. MOTHER'S MAIDEN NAME <u>Cora Thelto</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-01-1820</u>		17. INFORMANT <u>Mamie L. Duncan B.S.D. 1 B. 34 Hombridge Rd</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592X</u> <u>Renal insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic glomerular nephritis</u> DUE TO (c) <u>embolism</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/20</u> , 19 <u>58</u> , to <u>2/28</u> , 19 <u>58</u> that I last saw the deceased alive on <u>2/27</u> , 19 <u>58</u> , and that death occurred at <u>6:25 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>68 Franklin St. - An</u> DATE SIGNED <u>2/26/58</u> ACTUAL SIGNATURE <u>Richard A. Guler</u> M.D. <u>Annopolis, Md</u> PHYSICIAN'S NAME (Type) <u>Annopolis, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-1-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Davidsonville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beebe #108 Wash. St. Annapolis Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 28 1959

RECEIVED

CERTIFICATE OF DEATH

01450

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxen Hill, Md.</b>	
c. LENGTH OF STAY IN 1b <b>45 years</b>		d. STREET ADDRESS <b>16 X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Edelen</b> Last <b>Edelen</b>		4. DATE OF DEATH Month <b>2</b> Day <b>23</b> Year <b>19 58</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) yrs. <b>70</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral Hemorrhage</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>6-10 years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Unknown</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Unknown</b>		20f. (City or town) (County) (State) <b>Unknown</b>	
21. I certify that I attended the deceased from <b>February 23, 1958</b> to <b>February 23, 1958</b> , that I last saw the deceased alive on <b>February 23, 1958</b> , and that death occurred at <b>10:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Crownsville, Md.</b> DATE SIGNED <b>2/24/58</b>			
ACTUAL SIGNATURE <b>Ludwig Benedikt</b>		M.D. <b>Crownsville State Hospital, Crownsville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Ludwig Benedikt</b>		Crownsville, Md. <b>2/24/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>3.3.58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>U. of Md. Med. School</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William P. Reese</b>		24a. REC'D BY REGISTRAR <b>MAR 4 '58</b>	
ADDRESS <b>108 Wash St. Annapolis, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

1950

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>A. A. County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>A.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Neade</b>	c. LENGTH OF STAY IN 1b <b>2 Yrs</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt 2 Box 54-A-</b>		d. STREET ADDRESS <b>Rt 2 Box 54-A Severn Md</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Perry</b> Middle <b>Elam</b> Last		4. DATE OF DEATH Month <b>2</b> Day <b>14</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	11. BIRTHPLACE (State or foreign country) <b>Macon N.C</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Rufus Harvey</b>		14. MOTHER'S MAIDEN NAME <b>Mary collins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Oglesby Rt- Box 54-A Severn Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident, Massive, Right</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b> <b>Many years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 15, 1955</b> , to <b>February 15, 1958</b> , that I last saw the deceased alive on <b>February 15, 1958</b> , and that death occurred at <b>2:10 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. Rodenberry Shipley</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>2-15-58</b>	
PHYSICIAN'S NAME (Type) <b>Baltimore - Maryland #1</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 19, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Norfolk Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ELROY O. WILSON FUNERAL HOME 1000 Brantley Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 27 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Overhill</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the county or prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

FEB 27 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Laurel</b>		c. LENGTH OF STAY IN 1b <b>40 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>District Training School, Children's Center</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nathaniel Erkins</b>		4. DATE OF DEATH Month Day Year <b>February 26 19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 7, 1944</b>
9. AGE (In years last birthday) <b>13</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George Daniels (Putative)</b>		14. MOTHER'S MAIDEN NAME <b>Pearl Erkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Social Service, Children's Center, Laurel, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Vomiting and aspiration</b> 753.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Convulsive disorder</b> DUE TO (c) <b>Cerebral agenesis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Spastic quadriplegia with severe mental retardation</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>--</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 17, 1958</b> , to <b>February 26, 1958</b> , that I last saw the deceased alive on <b>February 26, 1958</b> , and that death occurred at <b>12:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Wilfred R. Ehrmantraut M.D.</b> <b>2/26/58</b>			
ACTUAL SIGNATURE <b>Wilfred R. Ehrmantraut</b>		PHYSICIAN'S NAME (Type) <b>Wilfred R. Ehrmantraut, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>2-26-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Va</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James E. Ch...</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 28 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>...</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
Vitalis		40 days		Male	
Cause of Death		Date of Death		Place of Death	
Asphyxiation		February 13, 1933		Home, 100 West Street, Boston, Mass.	
Occupation		Date of Birth		Place of Birth	
None		April 7, 1943		Boston, Mass.	
Signature of Physician		Signature of Registrar		Signature of Informant	
George J. Davis, M.D.		[Signature]		[Signature]	
Social Services, City of Boston		[Signature]		[Signature]	
Verified and attested		[Signature]		[Signature]	
Consent of Burial		[Signature]		[Signature]	
Consent of Burial		[Signature]		[Signature]	

BUREAU V. S.

FEB 28 1933

RECEIVED

PAID BOND

CERTIFICATE OF DEATH

Reg. Dist. No.

01453

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>L.</b> Last <b>FALLON</b>				4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>1958</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1879</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plant Dept. (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frank Fallon</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Grogan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-03-6306</b>		17. INFORMANT Address <b>Raleigh, N. C.</b> <b>Mrs. Harlan W. Hooe, Jr.-369 Meredith St. /</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dependent pneumonia</b> <b>446 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis with nephrosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1-2 wks</b> <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 1</b> , 19 <b>58</b> , to <b>Feb 26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb 26</b> , 19 <b>58</b> , and that death occurred at <b>10:30</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John L. Hedeman</b> M.D.				ADDRESS (Street, city or town, state) <b>68 Fremelin St. Annapolis, Md</b>		DATE SIGNED <b>2/27/58</b>	
PHYSICIAN'S NAME (Type) <b>Annapolis, Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 1, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Tiekner 4 hours - 1200 17th</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 28 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be notified. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
VS A15 (4)  
15M 9/55

BUREAU V. I.

1958 3

RECEIVED



## CERTIFICATE OF DEATH

01454

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>A Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>8 Wks.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Edward</b> Last <b>Fletcher</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>26</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-22-1866</b>	
9. AGE (In years last birthday) <b>91 1/2</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Navy Veteran</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (State or foreign country) <b>Prince George Co. Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Mary Scott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Spanish-American-W.W.I</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Charles W. Fletcher-1009 Wheeler Ave. Balt. Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>1-5-58</b> , 19 <b>58</b> , to <b>2-26-58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2-26-58</b> , 19 <b>58</b> , and that death occurred at <b>7:15</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. T. Allen</b>				ADDRESS (Street, city or town, state) <b>Cathedral Street-Annapolis, Md.</b>			
DATE SIGNED <b>6 L</b>							
PHYSICIAN'S NAME (Type) <b>A. T. Allen</b>				Cathedral Street-Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-2-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks III</b>				ADDRESS <b>Annapolis Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 5 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, pages 1 and 2 should be filed with the funeral home. Pages 1 and 2 should be filed with the funeral home. Pages 1 and 2 should be filed with the funeral home. Pages 1 and 2 should be filed with the funeral home.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
John Doe		Male		45		1910		Baltimore		Maryland		United States		United States	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		RE-MARRIED		OTHER		REMARKS	
MARRIED		SINGLE		MARRIED		DIVORCED		WIDOWED		RE-MARRIED		OTHER		REMARKS	
DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE		REMARKS		REMARKS		REMARKS	
1935		Baltimore		Maryland		United States		United States		REMARKS		REMARKS		REMARKS	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		REMARKS		REMARKS	
Heart Disease		Natural		Baltimore		Maryland		United States		United States		REMARKS		REMARKS	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		REMARKS		REMARKS		REMARKS	
1958		Baltimore		Maryland		United States		United States		REMARKS		REMARKS		REMARKS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CLERK		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	
John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
1958		1958		1958		1958		1958		1958		1958		1958	

BUREAU Y. 3

APR 5 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or the designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01455

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>83x-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1424 MANOR NURSING HOME</b>		d. STREET ADDRESS <b>1409 West Leigh Street</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>Fox</b> Last <b>Fox</b>		4. DATE OF DEATH Month <b>2</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 10, 1902</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>6</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Richmond Va</b>	
11. BIRTHPLACE (State or foreign country) <b>Richmond Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>Richmond-Va.</b>	
13. FATHER'S NAME <b>Cornie Lee Fox</b>		14. MOTHER'S MAIDEN NAME <b>Lelia Carter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>William Fox, 1409 Leigh St Richmond-Va.</b>	
17. INFORMANT <b>William Fox, 1409 Leigh St Richmond-Va.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exposure - To Cold</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>932.7</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>FOUND DEAD IN SNOW BANK</b>	
20c. TIME OF INJURY Month, Day, Year <b>12-8 2/17 1958</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Yard Nursing Home</b>		20f. (City or town) (County) (State) <b>Glen Burnie-AA-MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. S. FISHER</b>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R. S. FISHER</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2/18/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-21-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Lany-802 Madison Ave.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>Feb 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Smith</b>	

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.  
FEB 21 1973

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

01456

Reg. Dist. No. ....

1489 Item 7 FilmG226 2-28-58 et

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MD</u> COUNTY <u>✓</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>		TOWN <u>3001.4</u>	
CITY OR TOWN <u>Green Burnie</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location) <u>2422 BRENTWOOD AVE.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Plaza Manor Conv. Home</u>							
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Anna (ANNIE) FRAZIER</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Feb 20 1958</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>C</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>1-5-1893</u>	<b>9. AGE last birthday</b> <u>65</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic Private Family</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Acomac Co., Va.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>George Taylor</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Sabra Polson</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>?</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Ardella Frazier - 2408 Brentwood Ave.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>331X IMMEDIATE CAUSE (A)</b> <u>Cerebro-vascular accident</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>ARTERIOSCLEROSIS GENERAL</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Jan 6, 1958, to Feb 20, 1958, that I last saw the deceased alive on Feb 15, 1958, and that death occurred at 3:30 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Tracy Taylor</u>				<b>ADDRESS</b> (Street, city, town, state) <u>M.D. 12014 Blvd. B.E. Cedarhurst, Ind. 2-20-58</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>2/24/58</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Auburn</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Balto., Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Charles R. Law</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles R. Law</u>		<b>ADDRESS</b> <u>802 Mad. Ave.</u>	
<b>DATE</b> <u>FEB 25 '58</u>							



# CERTIFICATE OF DEATH

Form No. 100

1. NAME OF DECEASED

2. SEX OF DECEASED

3. DATE OF BIRTH	4. PLACE OF BIRTH	5. MARRIAGE	6. OCCUPATION
7. COLOR	8. RELIGION	9. EDUCATION	10. SOCIAL CLASS

11. CAUSE OF DEATH	12. PLACE OF DEATH	13. TIME OF DEATH	14. SEX OF DECEASED
15. NAME OF PHYSICIAN	16. NAME OF HOSPITAL	17. NAME OF NURSE	18. NAME OF ATTENDING PHYSICIAN

19. NAME OF FUNERAL HOME	20. NAME OF BURIAL PLACE	21. NAME OF CEMETERY	22. NAME OF INTERMENT
23. NAME OF CARRIER	24. NAME OF DRIVER	25. NAME OF ASSISTANT	26. NAME OF ATTENDING PHYSICIAN

BUREAU V. S.

FEB 25 1938

RECEIVED

NOTIFICATION

NOTIFICATION OF DEATH TO BE FURNISHED TO THE LOCAL HEALTH OFFICE BY THE PHYSICIAN OR FUNERAL HOME. THIS NOTIFICATION SHOULD BE FURNISHED WITHIN 24 HOURS OF THE DEATH. IT SHOULD BE FURNISHED TO THE LOCAL HEALTH OFFICE IN THE FOLLOWING MANNER: BY MAIL, BY TELEPHONE, OR BY PERSONAL DELIVERY. IF BY MAIL, IT SHOULD BE SENT BY REGISTERED MAIL. IF BY TELEPHONE, IT SHOULD BE CONFIRMED BY MAIL. IF BY PERSONAL DELIVERY, IT SHOULD BE DELIVERED TO THE LOCAL HEALTH OFFICE WITHIN 24 HOURS OF THE DEATH. THE NOTIFICATION SHOULD BE FURNISHED TO THE LOCAL HEALTH OFFICE IN THE FOLLOWING MANNER: BY MAIL, BY TELEPHONE, OR BY PERSONAL DELIVERY. IF BY MAIL, IT SHOULD BE SENT BY REGISTERED MAIL. IF BY TELEPHONE, IT SHOULD BE CONFIRMED BY MAIL. IF BY PERSONAL DELIVERY, IT SHOULD BE DELIVERED TO THE LOCAL HEALTH OFFICE WITHIN 24 HOURS OF THE DEATH.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01457

1446

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b <i>10</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>AA General</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Frederick L. J. Gelhaus</i>				4. DATE OF DEATH Month Day Year <i>2 19 1958</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>1-27-1891</i>	9. AGE (In years last birthday) <i>67</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>D.A.V.</i>		11. BIRTHPLACE (State or foreign country) <i>Annapolis Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frederick L. J. Gelhaus</i>				14. MOTHER'S MAIDEN NAME <i>Antoinette Rehn</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>World War I WW I</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Frederick L. Gelhaus</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart disease</i> 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. Linhardt</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. Linhardt</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-22-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Esq</i>				24a. REC'D BY REGISTRAR FEB 24 58 DATE		24b. REGISTRAR'S SIGNATURE <i>W. Schuch</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

FEB 24 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1490

## CERTIFICATE OF DEATH

01458

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PASADENA</b>	c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>03X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>214 CAARENDON AVE</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>BESSIE</b> First Middle Last <b>Y GORMLEY</b>		4. DATE OF DEATH Month <b>FEB</b> Day <b>22</b> Year <b>1958</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 21 1884</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>JAMES WILSON</b>		14. MOTHER'S MAIDEN NAME <b>MARY ALLENDER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>WALTER E. GORMLEY</b> Address <b>PASADENA, MD.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>GENERALIZED ARTERIOSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 HOURS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>FEB 19</b> , 19 <b>58</b> , to <b>FEB 22</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>FEB 19</b> , 19 <b>58</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Arthur Lankford Jr.</b> M.D. <b>Mountain Rd. Pasadena, Md.</b> PHYSICIAN'S NAME (Type) <b>ARTHUR LANKFORD JR.</b> <b>PASADENA, MARYLAND.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2-26-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Governor Ritchie Highway</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. RECEIVED BY REGISTRAR DATE <b>FEB 27 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. Lankford</b>

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 14

FEB 27 1958

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1491

## CERTIFICATE OF DEATH

Reg. Dist. No. 01459

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Docwood Rd #5</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Terrace Gardens, Arnold</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Merchant</u> Last <u>Graves</u>		4. DATE OF DEATH Month <u>2</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 26, 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>7</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cordova Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James F. Godwin</u>		14. MOTHER'S MAIDEN NAME <u>Emma Merchant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>260x</u>	
17. INFORMANT <u>MRS. Ethel Zimmerman, Siemens 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V. Disease</u> (c) <u>Diabetes Mellitus</u> <u>Gen. Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>53</u> , to <u>1958</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>19 Feb</u> , 19 <u>58</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>2-21-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		<u>Severna Park Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping + KIRK</u>		24a. REC'D BY REGISTRAR <u>Glen Buemie, Md</u> ADDRESS <u>24b. REGISTRAR'S SIGNATURE</u> <u>FEB 24 '58</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

CERTIFICATE OF DEATH

FILE NO.

BUREAU V. S.

FEB 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01460

Reg. Dist. No.

1447

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>10 ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. HOSPITAL</u>				e. STREET ADDRESS <u>620 CHESAPEAKE ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANGUS McDONALD GREEN</u>				4. DATE OF DEATH Month Day Year <u>2-23 1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>WH</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 1904</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>GEORGIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JAMES W. GREEN</u>				14. MOTHER'S MAIDEN NAME <u>HANNA LOCKE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>JAMES GREEN CULPEPER, VA</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of middle cerebral artery</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 hr.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-23-1958</u> , to <u>2-23-1958</u> , that I last saw the deceased alive on <u>2-23-1958</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D. <u>63 College Ave.</u>				ADDRESS (Street, city or town, state) <u>ANNAPOLIS, MD.</u> DATE SIGNED <u>2-23-58</u>			
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-25-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Culpeper VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clare Funeral Home</u>				ADDRESS <u>Culpeper, VA.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 25 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

BUREAU V. S.

FEB 25 1950

RECEIVED

1448

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenwood Acres</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospt.</u>		d. STREET ADDRESS <u>108 Second St.</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>O.</u> Last <u>Greene</u>		4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-18-1911</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS/OR INDUSTRY <u>Public School</u>	11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Greene</u>	
14. MOTHER'S MAIDEN NAME <u>Alice Shreve</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year of date of service) <u>WW II</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Anne Smith Greene</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>5 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Nov. 2-13-58</u> , 19 <u>58</u> , to <u>Feb. 13-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-13-58</u> , 19 <u>58</u> , and that death occurred at <u>7:55 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>63 College Ave</u> DATE SIGNED <u>2-13-58</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		<u>Annapolis Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-16-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u>	22d. LOCATION (City, town, or county) <u>Huntington W. Va</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Div. No.

MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

BUREAU V. B.  
FEB 19 1953

RECEIVED

1449

## CERTIFICATE OF DEATH

01462  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>A. C. General Hosp</u>		d. STREET ADDRESS <u>1950 A West St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Harried</u> Last <u>Harried</u>		4. DATE OF DEATH Month <u>2</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cal</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-9-1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Durham, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Jones</u>		14. MOTHER'S MAIDEN NAME <u>Florence Hunt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Thrombosis</u> 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 wks</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-3-58</u> 19, to <u>2-28-58</u> 19, that I last saw the deceased alive on <u>2-27-58</u> 19, and that death occurred at <u>12 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u> M.D.		ADDRESS (Street, city or town, state) <u>6 L Cathedral</u> DATE SIGNED <u>2-28-58</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		<u>Annapolis, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>3-3-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belleville</u>	22d. LOCATION (City, town, or county) (State) <u>Belleville Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese M Anna, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE <u>MAR 3 '58</u>	<u>Overman</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

540 Day 112

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF CORONER		14. SIGNATURE OF JURY		15. SIGNATURE OF WITNESSES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01463

1492

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN TB 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First Middle Last Rufus James Hawkins		4. DATE OF DEATH Month 2 Day 20 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/10/1905
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-22-1220	
17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Disease 023X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Syphilis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 13, 19 58, to February 20, 19 58, that I last saw the deceased alive on February 20, 19 58, and that death occurred at 1:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Hildegard Heard Reissmann		ADDRESS (Street, city or town, state) DATE SIGNED 2/21/58	
PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D.		Crownsville State Hospital, Md.	
22a. (BURIAL) CREMATION, REMOVAL (Specify) 2/23/58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY St. John's		22d. LOCATION (City, town, or county) (State) Lower Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.E. Sewell Prince Frederick, Md.		24a. REC'D BY REGISTRAR DATE FEB 26 '58	
24b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13  
CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is mostly blank with some faint markings.

BUREAU V. S.

FEB 26 1938

RECEIVED



## 1493 CERTIFICATE OF DEATH

01464

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL PASADENA</b>		c. LENGTH OF STAY IN 1b <b>15 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RIVEIRA BEACH</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First <b>JOSEPH</b> Middle <b>HENTHORN</b> Last		4. DATE OF DEATH <b>FEB</b> Month <b>6</b> Day <b>1958</b> Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 10 1968</b>
9. AGE (In years last birthday) <b>29</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAIL ROADS</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>THOMAS HENTHORNE</b>		14. MOTHER'S MAIDEN NAME <b>MARY JANE MOFFET</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>KATHERINE HOPKINS</b> Address <b>421 N. London Ave BALTO. MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASC. HEART DISEASE</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HEPATIC INSUFFICIENCY</b> DUE TO (c) <b>SENILITY (CAACHEXIA)</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>1 1/2 YRS</b> <b>6 MO.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>GENERALIZED ARTERIOSCLEROSIS</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>FEB 6</b> , 1958, to <b>Feb 6</b> , 1958, that I last saw the deceased alive on <b>NEVER SAW ALIVE</b> 19, and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur Lankford Jr</b> ADDRESS (Street, city or town, state) <b>Mountain Rd. Pasadena, Md.</b> DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>ARTHUR LANKFORD JR</b> <b>PASADENA, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>Burial</b>		<b>Feb-10-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Mr. Dewet</b>		<b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<b>John F. Dewfel 5311 Edmondson Ave</b>		<b>DATE FEB 10 '58</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
		<b>DeWet</b>	

MEDICAL CERTIFICATION

U.S. DEPARTMENT OF HEALTH - BALTIMORE

FEB 10 1959

RECEIVED

1450

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater, Annapolis</b>				c. LENGTH OF STAY IN 1b <b>11 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hosp.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater,</b>			
				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Fulton</b> Last <b>Herbert</b>				4. DATE OF DEATH Month <b>2</b> Day <b>3</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/21/58</b> - <b>30</b> <b>41</b> yrs.	
9. AGE (In years last birthday) <b>41</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>7</b> Hours <b>1</b> Min.		IF UNDER 24 HRS. Months <b>1</b> Days <b>7</b> Hours <b>1</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taxi driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>United States</b>	
13. FATHER'S NAME <b>Elijah Herbert</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Rice</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lemuria</b> <b>260x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Kimmel Steel - Wilson Syndrome</b> DUE TO (c) <b>Acute M.</b> INTERVAL BETWEEN ONSET AND DEATH <b>1-7</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Drabuta Come</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1953</b> to <b>2/3/1958</b> , that I last saw the deceased alive on <b>2-3-58</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Frank M. Shipley</b> M.D. <b>63 College Ave</b>							
PHYSICIAN'S NAME (Type) <b>Frank M. Shipley, M.D.</b> <b>Annapolis, Md</b> <b>2-3-58</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-6-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>108 W. Washington St. Annapolis</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

1053 FEB 10 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the relevant information prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1451

Item 9 Film G226 2-28-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

01466

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>24 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>	
		d. STREET ADDRESS <u>Rural</u>	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ninnie</u> Middle <u>(none)</u> Last <u>HERRELL</u>		4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31, 1892</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Robert P. Herrall - Son -</u>		Address <u>Millersville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of cervix with generalized metastases</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>29 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September</u> , 1955, to <u>Feb. 21</u> , 1958, that I last saw the deceased alive on <u>Feb. 21</u> , 1958, and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edith Rodler</u>		ADDRESS (Street, city or town, state) <u>45 Franklin St.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Edith Rodler</u>		DATE SIGNED <u>2/21/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal-Burial</u>		22b. DATE THEREOF <u>2-21-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Harrell Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Nr Tazewell, Claiborne Co, Tenn</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>ANNAPOLIS, MD.</u>	
24a. REC'D BY REGISTRAR <u>FEB 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	



FEB 25 1958

**BUREAU V. S.**

RECEIVED

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01467

## CERTIFICATE OF DEATH

Reg. Dist. No. 23 -

1. PLACE OF DEATH a. COUNTY <i>Dundee Glen Burnie</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Dundee Glen Burnie</i> b. COUNTY <i>G. A. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie Md</i>		c. LENGTH OF STAY IN 1b <i>35 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Gladys</i> Middle <i>Welyatta</i> Last <i>Holland</i>		4. DATE OF DEATH Month <i>Feb</i> Day <i>4</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 2, 1923</i>
9. AGE (In years last birthday) <i>69</i> yrs.		10. IF UNDER 1 YEAR Months <i>-</i> Days <i>-</i> Hours <i>-</i> Min. <i>-</i>	11. IF UNDER 24 HRS. Months <i>-</i> Days <i>-</i> Hours <i>-</i> Min. <i>-</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William K. Duncan</i>		14. MOTHER'S MAIDEN NAME <i>Elyzabeth Reilly</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Mrs. William Clark</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute virus infection</i>			
DUE TO (b) <i>Chronic Valvular Disease of the Heart</i>			
DUE TO (c) <i>Diabetes</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>260X</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 3</i> , 1958, to <i>Feb 4</i> , 1958, that I last saw the deceased alive on <i>Feb 3</i> , 1958, and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James S. Beckingler M.D.</i>		DATE SIGNED <i>Feb 4, 1958</i>	
PHYSICIAN'S NAME (Type) <i>James S. Beckingler M.D.</i>		ADDRESS (Street, city or town, state) <i>108 Central Ave. Glen Burnie Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb 7, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Fort Myer, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard V. Singleton</i>		ADDRESS <i>Glen Burnie, Md.</i>	
24a. REC'D BY REGISTRAR <i>Feb 10 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Date of birth: _____</p>		<p>4. Place of birth: _____</p>	
<p>5. Date of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Manner of death: _____</p>	
<p>9. Signature of physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Date of registration: _____</p>		<p>12. Place of registration: _____</p>	
<p>13. Name of informant: _____</p>		<p>14. Address of informant: _____</p>	
<p>15. Signature of informant: _____</p>		<p>16. Date of completion: _____</p>	

BUREAU V. S.

FEB 10 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1495

## CERTIFICATE OF DEATH

01468

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. LENGTH OF STAY IN 1b <u>7ys, 8mos, 2ds</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1958</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Crownsville State Hospital, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
4. NAME OF DECEASED (Type or print) <u>Frank</u>		5. SEX <u>Male</u>	
6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Unknown</u>		9. AGE (In years last birthday) <u>71?</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. -----	
17. INFORMANT <u>Hospital Records</u>		Address -----	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Intestinal Hemorrhage</u> DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Psychosis</u>			
INTERVAL BETWEEN ONSET AND DEATH -----			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 24, 1958</u> , to <u>February 25, 1958</u> , that I last saw the deceased alive on <u>February 25, 1958</u> and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>2/25/58</u> ACTUAL SIGNATURE <u>Hildegard Heard Reissmann</u> M.D. PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissmann, M. D., Crownsville State Hospital, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>		22d. LOCATION (City, town, or county) (State) <u>Calto Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Bennett</u> ADDRESS <u>108 Wash. St. Annapolis</u>		24a. REC'D BY REGISTRAR <u>Mar 6 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Mar 6 '58</u>		25. REGISTRAR'S SIGNATURE <u>Mar 6 '58</u>	

# CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. S.

MAR 6 1958

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1496

## CERTIFICATE OF DEATH

01469

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Severna Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ritchie Highway</u>		d. STREET ADDRESS <u>1 Ritchie Highway</u>	
3. NAME OF DECEASED (Type or print) <u>John Edgar Hood</u> First Middle Last		4. DATE OF DEATH <u>Feb 10</u> Month Day Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 12 1893</u> 9. AGE (In years last birthday) <u>64</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Office Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David C. Hood</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Kaltenbach</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>111-111-1111</u>	
17. INFORMANT <u>Wife (Mamie Hood)</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Heart</u> (c) <u>Heart</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1954</u> , 19___, to <u>1958</u> , 19___, that I last saw the deceased alive on <u>2-9-58</u> , 19___, and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>2-10-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		<u>Severna Park Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 13 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. Singleton</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 13 1959

RECEIVED

CERTIFICATE OF DEATH

01470

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel County</i> <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glennburnie Md Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glennburnie a a Co Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Samuel</i> First <i>Howard</i> Middle <i>Howard</i> Last		4. DATE OF DEATH Month <i>7</i> Day <i>2</i> Year <i>1958</i>	
5. SEX <i>m</i>	6. COLOR OR RACE <i>e</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/28/1903</i>
9. AGE (In years last birthday) <i>54</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>md</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>William Howard</i>		14. MOTHER'S MAIDEN NAME <i>Frances Henry</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Samuel Howard</i>		Address <i>Frederick a a Co</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i> <i>443x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardio-vascular disease</i> DUE TO (c) <i>generalized arterio-sclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>4 years</i> <i>unknown</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>January 14, 1953</i> , to <i>February 2, 1958</i> , that I last saw the deceased alive on <i>February 1, 1958</i> , and that death occurred at <i>7:40 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. M. McLaughlin</i>		ADDRESS (Street, city or town, state) <i>Pasadena, Md.</i> DATE SIGNED <i>Feb. 3, 1958</i>	
PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>2/6/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Marley Neck</i>	22d. LOCATION (City, town, or county) (State) <i>a a Co., Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Z. Brown &amp; Son</i>		ADDRESS <i>108 W. Montgomery St.</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Reed Smith</i>	
DATE <i>FEB 7 '58</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained in the hospital or funeral home. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained in the hospital or funeral home. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained in the hospital or funeral home.

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

BUREAU V. 1

FEB 7 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1498

Mem 2 Film G226 3-17-58 et

## CERTIFICATE OF DEATH

01471

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. LENGTH OF STAY IN 1b <u>11mo, 23da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, Md. Baltimore</u>	
		d. STREET ADDRESS <u>Waverly Avenue</u> <u>Elkton, Md.</u>	
e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Howard</u> Last <u>Howard</u>		4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>81 1/2</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>9</u> Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York State</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Abram Howard</u>		14. MOTHER'S MAIDEN NAME <u>Lillian</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>_____</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.0</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cancer of the Prostata Glands</u> DUE TO (c) <u>_____</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>_____</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>_____</u> p. m. <u>_____</u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u>		20f. (City or town) (County) (State) <u>_____</u>	
21. I certify that I attended the deceased from <u>February 17, 1957</u> to <u>February 9, 1958</u> , that I last saw the deceased alive on <u>February 9, 1958</u> and that death occurred at <u>9:10AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>2/10/58</u> ACTUAL SIGNATURE <u>Hildegard Heard Reissmann</u> M.D. PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissmann, M. D.</u> <u>Crownsville State Hospital, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal 2-11-58</u>		22b. DATE THEREOF <u>2-11-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wol. Med. Med. School</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reiss #108 Wash. St. Anna, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 14 '58</u>	
ADDRESS <u>_____</u>		24b. REGISTRAR'S SIGNATURE <u>Reissmann</u>	



CERTIFICATE OF DEATH

BUREAU V. S.

FEB 14 1958

RECEIVED

1499

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>30 Pleasant</i>	c. LENGTH OF STAY IN 1b <i>18 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>130 Pleasant</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>William</i> First Middle <i>Chrelend</i> Last		4. DATE OF DEATH <i>Feb.</i> Month <i>15</i> Day <i>1958</i> Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 11 1891</i>
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR Months <i>11</i> Days <i>11</i> Hours <i>11</i> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>St. Margarets</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William Chrelend</i>	
14. MOTHER'S MAIDEN NAME <i>Bettie (unknown)</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Joseph Chrelend</i> Address <i>St. Margarets</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> DUE TO <i>Arteriosclerosis</i> (c) <i>Cardiovascular disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb 13, 1958</i> to <i>Feb 24, 1958</i> , that I lost saw the deceased alive on <i>Feb 13, 1958</i> , and that death occurred on <i>Feb 15, 1958</i> at <i>11:04 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. L. Richardson</i>		ADDRESS (Street, city or town, state) <i>150 - CHAT ST ANNAPOLIS, MD</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>Feb 24 1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Feb. 21, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Broadneck</i>	22d. LOCATION (City, town, or county) (State) <i>Broadneck A. A. Co. Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. B. Johnson</i>		ADDRESS <i>Annapolis, Md.</i>	
24a. REC'D BY REGISTRAR <i>Feb 21 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 21 1959

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01473

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A. County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md 10</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>DoA-Anne Arundel General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>CAROLINE A JACOBS</i>	4. DATE OF DEATH <i>2-15-1958</i>	5. AGE (In years last birthday) <i>6</i> yrs. IF UNDER 1 YEAR: Months <i>6</i> Days <i>6</i> Hours <i>6</i> Min.	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-20-1957</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph A. Jacobs Jr.</i>		14. MOTHER'S MAIDEN NAME <i>Alice Booth</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Alice Jacobs 144 Cherry Ct.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE PURULENT OTITIS MEDIA</i> 392.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Russell S Fisher</i> M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Russell S FISHER</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-21-1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese #108108 St. Anna Md</i>		24. REC'D BY REGISTRAR <i>FEB 27 '58</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Deborah</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.



RECEIVED  
FEB 07 1958  
BUREAU V. 3



## CERTIFICATE OF DEATH

01474

Reg. Dist. No.

1453

1. PLACE OF DEATH o. COUNTY <u>Ar. a. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>a. a. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mulberry Hill a. a. Co.</u>		d. STREET ADDRESS <u>Mulberry Hill Md</u>	
3. NAME OF DECEASED (Type or print) <u>Benjamin</u> First <u>Johnson</u> Middle <u>John</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-6-1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired pension U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elizabeth Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Kimball</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, and if yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Ella Johnson Mulberry Hill Md</u>	
17. INFORMANT <u>Ella Johnson</u> Address <u>Mulberry Hill Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>5233</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Aspirin</u> DUE TO (c) <u>Aspirin</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-30-57</u> , 19 <u>57</u> , to <u>2-9-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-8-58</u> , 19 <u>58</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.T. Allen</u>		DATE SIGNED <u>2-11-58</u>	
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		ADDRESS (Street, city or town, state) <u>Annapolis, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-12-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Broadneck Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beece</u> ADDRESS <u>#108 Nash St. Annapolis</u>		24a. REC'D BY REGISTRAR <u>FEB 20 1958</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH			
MARITAL STATUS		OCCUPATION		EDUCATION		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF SURVIVORS		SIGNATURE OF BURIAL		SIGNATURE OF CREMATION		SIGNATURE OF OTHER		SIGNATURE OF OTHER	

BUREAU V. S.

FEB 20 1900

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01475

1500

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. LENGTH OF STAY IN 1b <u>Over 20 years.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Queenstown Rd.</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Priestly Johnson</u>				4. DATE OF DEATH Month <u>February</u> Day <u>11th</u> Year <u>58</u> 19			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/30/1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>South Carolina</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Isaac Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>  </u>			
17. INFORMANT <u>Neomi Carter</u>				Address <u>1140 Argyle Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>General Arteriosclerosis and exposure to</u> <u>450.0</u> DUE TO <u>cold weather.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>2/12/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Rice</u>				ADDRESS <u>661 W. Barre Street</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 14 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 14 1958

BUREAU V. S.

RECEIVED  
FEB 14 1958

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
DEPT.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the funeral home. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral home prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01476

Reg. Dist. No.

1501

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. LENGTH OF STAY IN 1b <u>1mo., 4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Johnson</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>90?</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Steven Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Emily</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Disease</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C. N. S. Syphilis</u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>January 23</u> , 19 <u>58</u> , to <u>February 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>February 27</u> , 19 <u>58</u> , and that death occurred at <u>2:40 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>2/28/58</u>			
ACTUAL SIGNATURE <u>Hildegard Heard Reissmann</u>			
PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissmann, M. D. Crownsville State Hospital, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>		22d. LOCATION (City, town, or county) (State) <u>29 S. Green St. Balt., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William R. Rickett</u>		24a. REC'D BY REGISTRAR <u>  </u>	
ADDRESS <u>108 Wash. St. Annapolis</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>MAR 6 '58</u>		DATE <u>  </u>	



CERTIFICATE OF DEATH

CLAIM BOND

BUREAU V. S.

MAR 6 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1454

## CERTIFICATE OF DEATH

01477

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>A</u> Last <u>KIMBALL</u> SR.		4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber-ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Simon Kimball</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Lamb</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>212-18-6502</u>	
17. INFORMANT <u>Mrs Louise S. Kimbill</u>		Address <u>Wife same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION &amp; MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIO-VASCULAR DISEASE</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>8 DAYS</u> <u>10 YRS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>54</u> , to <u>13 FEB</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>13 FEB</u> , 19 <u>58</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>2/14/58</u>			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 15, 58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 81

FEB 18 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or reinterment.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01478

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>EDGEWATER</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospital</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>SAMUEL</u> Last <u>KOLBE</u>		4. DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-1957</u>
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>JAMES S. KOLBE JR.</u>		14. MOTHER'S MAIDEN NAME <u>VIRGINIA LEE JOHNSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT <u>JAMES S. KOLBE #2</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>asphyxia</u> 9240 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>Chin face down in creek at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>2/18/58</u> 19 p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>
20f. (City or town) <u>AAco</u>		(County) <u>MD</u> (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>F. L. W. H. S. D. T.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. L. W. H. S. D. T.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2/18/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/22/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. ANNES CEDAR BLUFF</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. G. L. + Sons</u>		24a. REC'D BY REGISTRAR <u>Feb 24 '58</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Reese</u>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G225 2-24-58 et

CERTIFICATE OF DEATH

01479

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNAP ARUNDAL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>NEW JERSEY</u> b. COUNTY <u>BERGEN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Park (County)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>103 - 7th Ave. Balto. 25</u>		d. STREET ADDRESS <u>554 Riverdale Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>Bornice</u> Last <u>Koppel</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-17</u>
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto, Md</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Simon Barry Glass</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Glass</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Richard Koppel - Same</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute heart failure</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Breast (Bilateral)</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u> <u>3 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>	
21. I certify that I attended the deceased from <u>Sept 15, 1954</u> , to <u>Feb 14, 1958</u> , that I last saw the deceased alive on <u>Feb 14, 1958</u> , and that death occurred at <u>2:54 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis J. Glass</u>		ADDRESS (Street, city or town, state) <u>320 Retapsa Ave Balto 25 Md</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS J. Glass MD</u>		DATE SIGNED <u>2/14/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		22b. DATE THEREOF <u>2-14-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u>		ADDRESS <u>2100 Euteria Place</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

RECEIVED

FEB 18 1953

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1503

CERTIFICATE OF DEATH

Reg. Dist. No.

01480

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>6 Mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>S.</u> Last <u>Kozieracki</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1910</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Box Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stanley Kozieracki</u>		14. MOTHER'S MAIDEN NAME <u>Helen Skladarek</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>216-03-4470</u>	
17. INFORMANT <u>Theresa Kozieracki</u>		Address <u>825 Umbra St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHIAL CA</u> <u>162.1</u> DUE TO <u>WITH BONE METASTASIS IN</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> DUE TO <u>SPINE AND PELVIS</u> lying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-1, 1958</u> to <u>2-21-58</u> , that I last saw the deceased alive on <u>2-21</u> , 19 <u>57</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>OTTO Vogel MD</u>		ADDRESS (Street, city or town, state) <u>Box 441-A</u>	
PHYSICIAN'S NAME (Type) <u>OTTO VOGEL, M.D</u>		DATE SIGNED <u>2-23-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/26/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Meter</u>		24a. REC'D BY REGISTRAR <u>4015 Chester St</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred</u>		DATE <u>FEB 25 '58</u>	

FEB 25 1962

BUREAU V. S.

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1504

## CERTIFICATE OF DEATH

Reg. Dist. No.

01481

1. PLACE OF DEATH o. COUNTY <u>AA</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLD</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Box 377, Rt. 2, Arnold.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ARNOLD, Maryland</u>			d. STREET ADDRESS <u>—</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stanley W Lerp</u>			4. DATE OF DEATH Month Day Year <u>February 11 1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 11-1904</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELEC.</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>BALTO, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>WALTER LERP</u>			14. MOTHER'S MAIDEN NAME <u>AGNES Rudolph</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u> (If yes, give war or dates of service)	17. INFORMANT <u>Family</u> Address <u>Same</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>(Inoperable)</u> DUE TO (c) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>October 21 1957</u> , to <u>February 11 1958</u> , that I last saw the deceased alive on <u>February 10 1958</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Francis I. Codd</u>		M.D. <u>Box 289, Severna Park, Maryland</u>		DATE SIGNED <u>2/11/58</u>	
PHYSICIAN'S NAME (Type) <u>Francis I. Codd, M. D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-14-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Co.</u>	22d. LOCATION (City, town, or county)	(State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McGully Funeral Home</u> ADDRESS <u>130 E Fort Ave</u>			24a. REC'D BY REGISTRAR <u>Feb 14 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5021

RECEIVED

FEB 14 1953

BUREAU V. S.

1505

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A. County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A. County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jacobsville Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jacobsville Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Jacobsville Md</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>Lewis</i> Last		4. DATE OF DEATH Month <i>2</i> Day <i>13</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-15-1894</i>
9. AGE (In years last birthday) <i>63</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>South Carolina U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>7</i>		14. MOTHER'S MAIDEN NAME <i>7</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>124-03-7739</i>	
17. INFORMANT <i>Elizabeth Lewis Jacobsville Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Arteriosclerotic Cardio-vascular disease</i> DUE TO (c) <i>Cardiac decompensation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>3 years</i> <i>6 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 12, 1950</i> to <i>February 13, 1958</i> , that I last saw the deceased alive on <i>February 12, 1958</i> , and that death occurred at <i>5:00 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. M. McLaughlin</i>		ADDRESS (Street, city or town, state) <i>Pasadena, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>		DATE SIGNED <i>Feb. 13, 1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-16-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Beesett, 108 N. Washington St.</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR <i>Feb 20 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. Beesett</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. 1

1953 FEB 20

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01483

Reg. Dist. No.

1456

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kentucky</u> b. COUNTY <u>Boyd</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>3 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EMILY</u> Middle <u>S</u> Last <u>LYON</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>21</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 2, 1879</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Martha, Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> <u>no</u> <u>404-20-3978B</u>	
16. SOCIAL SECURITY NO. <u>404-20-3978B</u>		17. INFORMANT <u>Mr. Alonzo E. Lyon- Husband- same as # 2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>72 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X DIABETES MELLITUS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>57</u> , to <u>22 FEB</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>22 FEB</u> , 19 <u>58</u> , and that death occurred at <u>2:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Southgate Ave. Annapolis, Md.</u> DATE SIGNED <u>Edward S. Beck</u>							
ACTUAL SIGNATURE <u>Edward S. Beck</u>		M.D. <u>Edward S. Beck</u>		PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL * BURIAL</u>	
22b. DATE THEREOF <u>2-22-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ASHLAND, KENTUCKY</u>		22d. LOCATION (City, town, or county) (State) <u>ASHLAND, KENTUCKY</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>	
ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Beach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

1958

BUREAU V. S.

FEB 25 1958

RECEIVED



Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> <u>Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Severna Park.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DOA</u> <u>A.A. Gen Hosp (not admitted)</u>		d. STREET ADDRESS <u>Md.</u>	
3. NAME OF DECEASED (Type or print) <u>William Mathew</u> <u>McPherson</u>		4. DATE OF DEATH <u>2-9-58</u> 19 <u>58</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25<sup>th</sup> 1901</u> 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boiler POWER PLANT</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel L. McPherson</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Hickemboatom</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Son Howard McPherson</u> # <u>(2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C.V. Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> , 19____, to <u>1958</u> , 19____, that I last saw the deceased alive on <u>2-9-58</u> , 19____, and that death occurred at <u>07A</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. HAHN</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>2-9-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		<u>Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-12-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 11 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Carl</u>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 4

1938

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or reinterment.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01485

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>F.A. GENERAL HOSPT.</u>		d. STREET ADDRESS <u>32 Bloomsbury Sq.</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM W. MEEKINS</u>		4. DATE OF DEATH <u>2</u> Month <u>6</u> Day <u>1958</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 15-1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>City employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Employee</u>	
11. BIRTHPLACE (State or foreign country) <u>Chesapeake Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Augustus Meekins</u>		14. MOTHER'S MAIDEN NAME <u>Martha Gray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Martha Wyatt Hewlett Va.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4344</u> DUE TO <u>Heart Disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (c), stating the underlying cause lost. DUE TO <u>-</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John M. Taylor</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Hewlett</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-9-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Belcrest Cemt.</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR <u>Feb 10 '58</u>	
ADDRESS <u>Annapolis Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Search</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 10 1953

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

01486

1507

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>MILLER</u> Last		4. DATE OF DEATH Month <u>February</u> Day <u>20</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 10, 1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Gehrde, Germany</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Mr Calvin L. Miller- Son- same as # 2</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arterio Sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>10 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>46</u> , to <u>Feb 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 19</u> , 19 <u>58</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward J. Skerritt</u>		DATE SIGNED <u>2-20-58</u>	
PHYSICIAN'S NAME (Type) <u>Edward J. Skerritt MD</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-20-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 25 '58</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Search</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration for prior to burial, cremation, or removal, and in any event within 72 hours after death.



1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

**BUREAU V. S.**

FEB 23 1959

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

1508

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL PASADENA</b>		c. LENGTH OF STAY IN 1b <b>16 MO.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7 BROOKVIEW RD. PASADENA MD.</b>		d. STREET ADDRESS <b>7 BROOKVIEW</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM RICHARD MOESSNER JR</b>		4. DATE OF DEATH <b>FEB. 7 1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1912 JULY 8 1918</b>
9. AGE (In years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LAUNDRY SUPT.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LAUNDRY</b>	
11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM RICHARD MOSSNER</b>		14. MOTHER'S MAIDEN NAME <b>KATHLEEN MARLOWE DAYTONA BEACH FLA.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>262-014656</b>	
17. INFORMANT <b>WIFE</b>		Address <b>PASADENA, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL FAILURE</b> <b>153.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA SIGMOID W/ METASTASIS</b> DUE TO (c) <b>CACHEXIA</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 HRS</b> <b>2 YRS</b> <b>3 MO.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HEPATIC INSUFFICIENCY</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY 1957</b> to <b>FEB 7 1958</b> , that I last saw the deceased alive on <b>FEB 6 1958</b> , and that death occurred at <b>4:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur Lankford Jr.</b>		ADDRESS (Street, city or town, state) <b>Mountain Rd. Pasadena, Md.</b>	
PHYSICIAN'S NAME (Type) <b>ARTHUR LANKFORD JR.</b>		M.D. <b>MOUNTAIN RD. PASADENA MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 10/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemo</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Glen Burnie</b>		ADDRESS <b>Glen Burnie</b>	
24a. REC'D BY REGISTRAR <b>DECEASED</b>		24b. REGISTRAR'S SIGNATURE <b>DECEASED</b>	

TO HOSPITAL OR FUNERAL HOME: This certificate must be retained for 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

1958

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01488

Reg. Dist. No.

**FOR STATE  
HEALTH DEPT.**

**1509**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>			c. LENGTH OF STAY IN 1b <b>50</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Front of 5420 Wasena Avenue</b>				d. STREET ADDRESS <b>5420 Wasena Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>VIOLA</b> Middle <b>C. (MEYER)</b> Last <b>MYERS</b>				4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 24-1908</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months <b>49</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>322.0 Exposure secondary to Acute Alcoholism.</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>932.0</b>							
INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found on pavement in front of home.</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>2/11 19 58</b> <b>Back</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>In front of home</b>		20f. (City or town) <b>Brooklyn</b> (County) <b>A. A.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Paul F. Guerin</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>				DATE SIGNED <b>2/11/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-14-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Brooklyn Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mc Cully Funeral Homes</b>				ADDRESS <b>130 E. Fortane</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 13 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Alb. Leach</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
A-100 ALXAMINE'S CERTIFICATE OF DEATH

RECEIVED  
FEB 13 1959  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1458

## CERTIFICATE OF DEATH

01489

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>				c. LENGTH OF STAY IN 1b <b>32 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Annapolis, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EMORY</b> Middle <b>WATSON</b> Last <b>O'CAIN</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>17</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-28-88</b>		9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy Ret.</b>		11. BIRTHPLACE (State or foreign country) <b>So. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Lewis R. O'CAIN</b>				14. MOTHER'S MAIDEN NAME <b>Ella PENNY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WWI WWII</b>		17. INFORMANT <b>U.S. Naval Hospital, Annapolis, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LUNG ACESS with aspiration</b> <b>141.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RHABDOMYOSARCOMA base of tongue with metastasis</b> DUE TO (c) <b>CHRONIC PYLONEPHRITIS AND ARTERIOSCLEROSIS PERIPHERAL</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Approx. 4wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>1-20</b> , <b>19 58</b> , to <b>2-17-</b> , <b>19 58</b> , that I last saw the deceased alive on <b>2-17-</b> , <b>19 58</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James W. Dinsmore</b>				ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Anna. Md.</b>			
DATE SIGNED <b>2-18-58</b>							
PHYSICIAN'S NAME (Type) <b>J. W. DINSMORE LT MC USNR</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>FEB. 21, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>				ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 21 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

$$\hat{I}^{\wedge} = \{I \in \mathcal{I} : I \cap I' = \emptyset \text{ for all } I' \in \mathcal{I} \text{ with } I' \neq I\}$$

FEB. 21 1953

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01490

Reg. Dist. No.

1510

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Davidsonville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Davidsonville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <b>1</b>		
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>PARKER</b> Last			4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>19 58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) <b>22</b> yrs.
			IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Davidsonville Md</b>	
				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas H. Parker</b>			14. MOTHER'S MAIDEN NAME <b>Martha Brown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Elizabeth A. Parker Davidsonville Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Partial</b>	
				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2/27/58</b>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-2-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>unum Chapel</b>	
22d. LOCATION (City, town, or county) (State) <b>Davidsonville Md</b>		24a. REC'D BY REGISTRAR <b>William Reese #108 Wash. St. Annapolis Md</b>		24b. REGISTRAR'S SIGNATURE <b>Feb 28 1958</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese #108 Wash. St. Annapolis Md</b>		ADDRESS		24c. REGISTRAR'S SIGNATURE <b>Feb 28 1958</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
DEPARTMENT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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may be retained by the funeral director, or by the funeral director, after this certificate has been signed by the attending physician and completely filled out. Pages 1 and 2 should be filed with the registrar. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1459

CERTIFICATE OF DEATH

01491

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>				c. LENGTH OF STAY IN 1b <u>4 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Anne Arundel Gen. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Maudie</u> Middle <u>Pemberton</u> Last <u>Pemberton</u>				4. DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-25-80</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Dandridge Pemberton</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-22-6870</u>		17. INFORMANT <u>Mrs. Mary Belanger</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular collapse</u> DUE TO (b) <u>Inanition</u> DUE TO (c) <u>Pulmonary Tuberculosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>undetermined in few hours seen in hospital</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>not known</u> <u>not known</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>-</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) (County) (State) <u>-</u>	
21. I certify that I attended the deceased from <u>Feb. 18, 5:45 PM 1958</u> , to <u>Feb. 18, 9:40 PM 1958</u> , that I last saw the deceased alive on <u>Feb. 18, 1958</u> , and that death occurred at <u>9:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Merton T. Waite</u>				ADDRESS (Street, city or town, state) <u>Cathedral &amp; Dean Sts.</u>			
PHYSICIAN'S NAME (Type) <u>Merton T. Waite</u>				DATE SIGNED <u>2-18-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 21, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Wood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Singleton</u>				ADDRESS <u>6100 Burns, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 21 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. J. Couch</u>			



CERTIFICATE OF DEATH

153

NAME OF DECEASED J. J. JONES		AGE 45		SEX Male		RACE White		DATE OF BIRTH Jan 15, 1888		PLACE OF BIRTH Baltimore, Md.	
DATE OF DEATH Feb 10, 1930		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		DISEASE OR INJURY Coronary Artery Disease	
SIGNATURE OF PHYSICIAN J. J. JONES		SIGNATURE OF WITNESS J. J. JONES		SIGNATURE OF DECEASED J. J. JONES		SIGNATURE OF NEXT OF KIN J. J. JONES		SIGNATURE OF CLERK J. J. JONES		SIGNATURE OF REGISTRAR J. J. JONES	
DATE OF REGISTRATION Feb 10, 1930		TIME OF REGISTRATION 10:30 AM		PLACE OF REGISTRATION Home		CAUSE OF REGISTRATION Heart Disease		MANNER OF REGISTRATION Natural		DISEASE OR INJURY Coronary Artery Disease	

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FEB 11 1930

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FEB 11 1930

1511

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A.A.CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LINTHICUM</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X LINTHICUM</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>200 S. CAMP MEADE RD.</u>		d. STREET ADDRESS <u>200 S. CAMP MEADE RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NICHOLAS</u> Middle <u>A.</u> Last <u>PFEIFFER</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 1, 1868</u> 9. AGE (In years last birthday) <u>89</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u>
13. FATHER'S NAME <u>NICHOLAS ADAM PFEIFFER</u>		14. MOTHER'S MAIDEN NAME <u>MARY METZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <u>MRS. AVERIL P. GARNER</u> Address <u>200 S. CAMP MEADE RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) <u>Pneumonia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic Heart Disease</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 yrs +</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 27</u> , 19 <u>58</u> , to <u>Feb 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 27</u> , 19 <u>58</u> , and that death occurred at <u>10:45 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Milton Linthicum</u>		ADDRESS (Street, city or town, state) <u>106 W. Maple Rd, Linthicum, Md.</u> DATE SIGNED <u>2/5/58</u>	
PHYSICIAN'S NAME (Type) <u>C. MILTON LINTHICUM, M.D., 106 W. MAPLE RD, A.A.CO. MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>FEB. 6/58</u>	<u>WESTERN CEM.</u>	<u>BALTO, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WITKE FUNERAL DIR.</u>		24a. REC'D BY REGISTRAR <u>Feb 5 1958</u> 24b. REGISTRAR'S SIGNATURE <u>Witke</u>	
ADDRESS <u>4101 EDMONDSON AVE.</u>		DATE	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1958 FEB 6

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CERTIFICATE OF DEATH

Reg. Dist. No.

01493

SANN'S Nursing Home

1. PLACE OF DEATH a. COUNTY <u>Anne - Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. LENGTH OF STAY IN 1b <u>3 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cecil-Rd.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastport, Md.</u>	
f. STREET ADDRESS <u>818 Bay Ridge Ave.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY -</u> Middle <u>L</u> Last <u>Phipps</u>		4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13-1983</u> 74 yrs.
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>14</u> Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Robert S Price</u>		14. MOTHER'S MAIDEN NAME <u>Emma Avery</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary V. Sann L.P.N.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 350x DUE TO <u>Pericardial Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-17-58</u> , 19 <u>58</u> , to <u>2-14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/31/58</u> , 19 <u>58</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eustace K. Phipps</u> M.D.		ADDRESS (Street, city or town, state) <u>5-Fairfax P.O.</u> DATE SIGNED <u>2/14/58</u>	
PHYSICIAN'S NAME (Type) <u>GUSTAVE H. FAUBERT</u>		<u>John Burdick, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-17-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Sayla Sins</u> ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR <u>1958</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
MILTON		M		30		1958	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION	
STUDENT		HIGH SCHOOL		MARRIED		METHODIST	
CAUSE OF DEATH		IMMEDIATE		INTERMEDIATE		FINAL	
HEART DISEASE		CORONARY		ARTERIO-SCLEROSIS		HYPERTENSION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
1958		10:00 AM		HOME		HEART DISEASE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
1958		1958		1958		1958	

BUREAU V. 31

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1460

CERTIFICATE OF DEATH

01494

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>A.A. CO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SEVERNA PARK A.A. CO., MD.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ANNE ARUNDEL GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>W.</b> Last <b>PIEHLER</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>26</b> Year <b>1958</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/8/1882</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LIFE INSURANCE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>FRANK PIEHLER</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. JENNIE T. PIEHLER #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute dilatation of heart</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Chr. Congestive Heart Failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 min (?)</b> <b>Yes -</b> <b>6 mos.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Pancreas - Metastasis to Liver &amp; other organs</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 12</b> , 19 <b>58</b> , to <b>Feb 26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb 26</b> , 19 <b>58</b> , and that death occurred at <b>4 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Maurice Klawans</b> M.D.				ADDRESS (Street, city or town, state) <b>31 SOUTHGATE AV ANNAPOLIS, MD.</b>			
PHYSICIAN'S NAME (Type) <b>MAURICE K. KLAWANS</b>				DATE SIGNED <b>2/27/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/1/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST</b>		22d. LOCATION (City, town, or county) (State) <b>ANNAPOLIS, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. TAYLOR AND SONS</b>				24a. REC'D BY REGISTRAR DATE <b>Mar 5 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Qu...</b>	

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1958 3

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01495

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> h. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp</u>		d. STREET ADDRESS <u>Delmont Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>"Baby"</u> First <u>Girl</u> Middle <u>Polacek</u> Last		4. DATE OF DEATH <u>February</u> Month <u>13</u> Day <u>1958</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 13, 1958</u>
9. AGE (In years last birthday) <u>10</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Polacek</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Henry Polacek</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>7600</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Placental insufficiency</u> DUE TO <u>Pre-eclampsia</u> (c) <u>Intestinal tran. embolism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Intestinal tran. embolism</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>happened while driving</u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Joseph C. Shuckman</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Joseph C. Shuckman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 16 58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>W. H. Deane</u>	

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CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to blurring and bleed-through.

BUREAU V. 2

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Bottom section of the form, likely for administrative use or signature, with fields for date and location. The text is mostly illegible.

1513

## CERTIFICATE OF DEATH

Reg. Dist. No. 01496

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Skidmore</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Skidmore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Log Run Road</i>		d. STREET ADDRESS <i>Log Run Road</i>	
3. NAME OF DECEASED (Type or print) <i>Charles</i> First <i>Porter</i> Middle <i>Porter</i> Last		4. DATE OF DEATH Month <i>2</i> Day <i>27</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-21-1886</i>
9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR Months <i>11</i> Days <i>11</i> Hours <i>11</i> Min.	IF UNDER 24 HRS. Months <i>11</i> Days <i>11</i> Hours <i>11</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sanitor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>State Ark</i>	
11. BIRTHPLACE (State or foreign country) <i>Skidmore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Porter</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>?</i>	
17. INFORMANT <i>Charles Porter Jr. Skidmore, Md.</i>		Address <i>Skidmore, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atherosclerosis Heart Disease</i> <i>420.0</i> DUE TO <i>with Enrystons Machine</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>?</i> DUE TO (c) <i>?</i>		INTERVAL BETWEEN ONSET AND DEATH <i>about 1 yr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>?</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <i>9.</i> p. <i>m.</i> 19 <i>58</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4-8-57</i> , 19 <i>57</i> , to <i>2-27-58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>2-21-58</i> , 19 <i>58</i> , and that death occurred at <i>7:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. T. Allen</i>		DATE SIGNED <i>2-28-58</i>	
PHYSICIAN'S NAME (Type) <i>A. T. ALLEN</i>		Address <i>61 Cathedral St Skidmore, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-3-1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Broad Neck</i>	22d. LOCATION (City, town, or county) (State) <i>Skidmore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese &amp; Anna, Md.</i>		ADDRESS <i>?</i>	
24a. REC'D BY REGISTRAR <i>W. J. Allen</i>		24b. REGISTRAR'S SIGNATURE <i>W. J. Allen</i>	
DATE <i>MAR 3 58</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. DATE OF DEATH	
3. TIME OF DEATH		4. PLACE OF DEATH	
5. NAME OF DECEASED		6. SEX	
7. AGE		8. RACE	
9. OCCUPATION		10. CAUSE OF DEATH	
11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN	
17. SIGNATURE OF CLERK		18. SIGNATURE OF JURY	
19. SIGNATURE OF JUDGE		20. SIGNATURE OF SHERIFF	
21. SIGNATURE OF CORONER		22. SIGNATURE OF DISTRICT ATTORNEY	
23. SIGNATURE OF COUNTY CLERK		24. SIGNATURE OF CITY CLERK	
25. SIGNATURE OF TOWN CLERK		26. SIGNATURE OF VILLAGE CLERK	
27. SIGNATURE OF PARISH CLERK		28. SIGNATURE OF CHURCH CLERK	
29. SIGNATURE OF SYNAGOGUE CLERK		30. SIGNATURE OF MOSQUE CLERK	
31. SIGNATURE OF TEMPLE CLERK		32. SIGNATURE OF CHANTRY CLERK	
33. SIGNATURE OF CHAPEL CLERK		34. SIGNATURE OF ALTAR CLERK	
35. SIGNATURE OF PULPIT CLERK		36. SIGNATURE OF DOOR CLERK	
37. SIGNATURE OF CHANCEL CLERK		38. SIGNATURE OF TRANSEPT CLERK	
39. SIGNATURE OF AISLE CLERK		40. SIGNATURE OF NAVE CLERK	
41. SIGNATURE OF CHURCH CLERK		42. SIGNATURE OF SYNAGOGUE CLERK	
43. SIGNATURE OF MOSQUE CLERK		44. SIGNATURE OF TEMPLE CLERK	
45. SIGNATURE OF CHANTRY CLERK		46. SIGNATURE OF CHAPEL CLERK	
47. SIGNATURE OF ALTAR CLERK		48. SIGNATURE OF PULPIT CLERK	
49. SIGNATURE OF DOOR CLERK		50. SIGNATURE OF CHANCEL CLERK	
51. SIGNATURE OF TRANSEPT CLERK		52. SIGNATURE OF NAVE CLERK	
53. SIGNATURE OF CHURCH CLERK		54. SIGNATURE OF SYNAGOGUE CLERK	
55. SIGNATURE OF MOSQUE CLERK		56. SIGNATURE OF TEMPLE CLERK	
57. SIGNATURE OF CHANTRY CLERK		58. SIGNATURE OF CHAPEL CLERK	
59. SIGNATURE OF ALTAR CLERK		60. SIGNATURE OF PULPIT CLERK	
61. SIGNATURE OF DOOR CLERK		62. SIGNATURE OF CHANCEL CLERK	
63. SIGNATURE OF TRANSEPT CLERK		64. SIGNATURE OF NAVE CLERK	
65. SIGNATURE OF CHURCH CLERK		66. SIGNATURE OF SYNAGOGUE CLERK	
67. SIGNATURE OF MOSQUE CLERK		68. SIGNATURE OF TEMPLE CLERK	
69. SIGNATURE OF CHANTRY CLERK		70. SIGNATURE OF CHAPEL CLERK	
71. SIGNATURE OF ALTAR CLERK		72. SIGNATURE OF PULPIT CLERK	
73. SIGNATURE OF DOOR CLERK		74. SIGNATURE OF CHANCEL CLERK	
75. SIGNATURE OF TRANSEPT CLERK		76. SIGNATURE OF NAVE CLERK	
77. SIGNATURE OF CHURCH CLERK		78. SIGNATURE OF SYNAGOGUE CLERK	
79. SIGNATURE OF MOSQUE CLERK		80. SIGNATURE OF TEMPLE CLERK	
81. SIGNATURE OF CHANTRY CLERK		82. SIGNATURE OF CHAPEL CLERK	
83. SIGNATURE OF ALTAR CLERK		84. SIGNATURE OF PULPIT CLERK	
85. SIGNATURE OF DOOR CLERK		86. SIGNATURE OF CHANCEL CLERK	
87. SIGNATURE OF TRANSEPT CLERK		88. SIGNATURE OF NAVE CLERK	
89. SIGNATURE OF CHURCH CLERK		90. SIGNATURE OF SYNAGOGUE CLERK	
91. SIGNATURE OF MOSQUE CLERK		92. SIGNATURE OF TEMPLE CLERK	
93. SIGNATURE OF CHANTRY CLERK		94. SIGNATURE OF CHAPEL CLERK	
95. SIGNATURE OF ALTAR CLERK		96. SIGNATURE OF PULPIT CLERK	
97. SIGNATURE OF DOOR CLERK		98. SIGNATURE OF CHANCEL CLERK	
99. SIGNATURE OF TRANSEPT CLERK		100. SIGNATURE OF NAVE CLERK	

BUREAU V. S.

MAR 3 1959

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## CERTIFICATE OF DEATH

01497

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>131 West Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Richardo</u> Middle <u>Priestley</u> Last <u>Priestley</u>		4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 20, 1958</u>
9. AGE (In years lost birthday) <u>Newborn</u>		IF UNDER 1 YEAR Months <u>infant</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carlwell Priestley</u>		14. MOTHER'S MAIDEN NAME <u>Sylvia Marie Dorsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mother</u>		Address <u>131 West St., Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> <u>761.0</u> DUE TO <u>Intermittent Asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Abruptio Placenta</u> (c) <u>18 hrs. 2 mos. - 18 hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>19</u> Day <u></u> Year <u></u> Hour o. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Dr. Stuart Christhill, Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>Dr. Stuart Christhill, Jr. Franklin St., Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3-1-1958</u>	<u>Brewer Hall</u>	<u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keese</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 28 '58</u>	
ADDRESS <u>108 Wash. St. Annapolis</u>		24b. REGISTRAR'S SIGNATURE <u>W. Keese</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

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## CERTIFICATE OF DEATH

Reg. Dist. No. 01498

1. PLACE OF DEATH o. COUNTY <u>A. A. County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>				c. LENGTH OF STAY IN 1b <u>10</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>56 Clay Street</u>				d. STREET ADDRESS <u>56 Clay Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>Randall</u> Last <u></u>				4. DATE OF DEATH Month <u>2</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cal.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-23-1892</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>J. B. Semple</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Summerside Randall</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Harris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give way or dates of service)				16. SOCIAL SECURITY NO. <u>212-30-721</u>			
17. INFORMANT <u>Lucile Henderson</u>				Address <u>56 Clay St. Annapolis Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>							
420.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Arteriosclerotic Hypertension</u>							
DUE TO							
(c) <u>Cardiovascular Disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Annapolis</u>		(County) <u>Prince Georges</u>		(State) <u>Md.</u>			
21. I certify that I attended the deceased from <u>Feb 12, 1958</u> to <u>Feb 13, 1958</u> , that I last saw the deceased alive on <u>Feb 12, 1958</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. B. [Signature]</u>				ADDRESS (Street, city or town, state) <u>110 - Clay St. Annapolis, Md.</u>			
DATE SIGNED <u>2/13/58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-16-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reesett</u>				ADDRESS <u>108 Wash. St. Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 20 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01499

Reg. Dist. No.

1514

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Severna Park</u>	c. LENGTH OF STAY IN 1b <u>3 months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Oak Lane Carlton Manor</u>		d. STREET ADDRESS <u>Same</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha Mae Rhodes</u>		4. DATE OF DEATH Month Day Year <u>February 1st. 19 58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/7/84</u>
9. AGE (In years last birthday) <u>73 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairstone, Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Greenleaf</u>		14. MOTHER'S MAIDEN NAME <u>Alice Friend</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Frank J. Rhodes (Husband)</u>	
17. INFORMANT <u>Mr. Frank J. Rhodes (Husband)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Probably aggravated by being submerged in</u> DUE TO (c) <u>8 inches of water while taking a bath.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in the bath tub 8 inches of water.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2/1/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. 25, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Murphy</u> <u>Hopping &amp; Kierney, Glen Burnie, Md</u>		24a. REC'D BY REGISTRAR <u>FEB 4 58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND  
DEPT. OF HEALTH

RECEIVED  
FEB 4 1958  
BUREAU V. 8

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1515

## CERTIFICATE OF DEATH

01500

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Md.</b>		c. LENGTH OF STAY IN 1b <b>5mos, 27das.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>Belle</b> Last <b>Richardson</b>		4. DATE OF DEATH Month <b>2</b> Day <b>19</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/26/02</b>
9. AGE (In years lost birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>58</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>South Carolina</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel Brannon</b>		14. MOTHER'S MAIDEN NAME <b>Priscilla Freshley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Renal Failure</b> DUE TO (c) <b>Hypertensive Cardio-vascular Renal Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right Hemiplegia due to Cardiovascular Accident</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>-----</b> 19 p. m. <b>-----</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State) <b>-----</b>	
21. I certify that I attended the deceased from <b>August 23, 1957</b> , to <b>February 19, 1958</b> , that I last saw the deceased alive on <b>February 19, 1958</b> , and that death occurred at <b>6:10 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>2/20/58</b>			
ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b>		M.D. <b>Crownsville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>		<b>Crownsville State Hospital, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-24-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial PK.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Randolph Collick</b>		24a. REC'D BY REGISTRAR <b>1412 E. PRESTON ST.</b>	
24b. REGISTRAR'S SIGNATURE <b>Aw. L. Smith</b>		DATE <b>FEB 27 '58</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

NAME OF DECEASED

SEX

EDUCATION

PROFESSION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

EDUCATION

PROFESSION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

EDUCATION

PROFESSION

BUREAU V. L.

FEB 27 1958

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

01501

1. PLACE OF DEATH a. COUNTY <u>Glen Burnie</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<u>Baltimore</u>		<u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Conv. Home-Furnace Br. Rd.</u>		d. STREET ADDRESS <u>315 Zepplin Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>RICHARDSON</u> Last <u>RICHARDSON</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cockeysville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Virginia Smith</u>		Address <u>320 Zepplin Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Hypertensive cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>2 wks</u> <u>5 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 6, 1958</u> to <u>Feb 9, 1958</u> , that I last saw the deceased alive on <u>Feb 6, 1958</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. R. Law</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>106 W. Popple Rd, Lutherville Md</u> <u>2/9/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-13-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		ADDRESS <u>802 Madison Avenue</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Smith</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

REG. DIST. NO.

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. DATE OF DEATH		7. PLACE OF BIRTH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES H. HARRIS		Male		45		White		1890		1935		Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		J. H. Harris		J. H. Harris	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
Teacher		High School		Roman Catholic		Married		None		None		None		None		None		None		None		None	
25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF DECEASED		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

BUREAU V. S.

FEB 13 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01502

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(WOODLAND BEACH) EDGEWATER</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FAIRFULL DRIVE</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X WOODLAND BEACH, EDGEWATER</b> d. STREET ADDRESS <b>FAIRFULL DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <b>ROY WILLIAM RINKER</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>FEBRUARY 21 1958</b> Month Day Year							
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Dec. 20, 1896</b>		<b>9. AGE</b> (In years last birthday) <b>61</b> yrs. <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Winchester, Va.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>UNKNOWN</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>UNKNOWN</b>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>224-10-8316</b>		<b>17. INFORMANT</b> <b>Wallace W. Ricker- Son- Edgewater, Maryland</b> Address					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular disease</b> DUE TO (c)								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>30 minutes</b> <b>4 years</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <i>Sylvia M. Lim</i> <b>EXAMINER'S NAME (Type)</b> <b>Sylvia M. Lim MD</b>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <b>2/23/58</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>Feb. 25, 1958</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Hebron Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> <b>Winchester, Virginia</b> (State)			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOPPING FUNERAL HOME</b> <b>Annapolis, Md.</b>						<b>24a. REC'D BY REGISTRAR</b> <b>DATE FEB 25 '58</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>W. L. Smith</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

FEB 25 1958

RECEIVED

1464

## CERTIFICATE OF DEATH

01503

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Grove Road RFD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Smith</u> Last <u>Sahn</u>		4. DATE OF DEATH Month <u>2</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-24-1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Warsaw Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Smith</u>		14. MOTHER'S MAIDEN NAME <u>Eva Noel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>M. Katherine Sahn</u>		Address <u>3024 W. Calvert St Apt F 1 Baltimore 18 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis generalisef</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>1 yr.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 1, 1957</u> to <u>2-5-1958</u> , that I last saw the deceased alive on <u>2-4-1958</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 SHAW ST. ANNAPOLIS, MD.</u> DATE SIGNED <u>2/6/58</u>			
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.			
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-7-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT Olivet Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u>		ADDRESS <u>Annapolis Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 1

Blank form for Certificate of Death with various fields for registration, medical history, and cause of death.

BUREAU V. S.

FEB 10 1953

RECEIVED



1465  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A.A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived; If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A.A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. LENGTH OF STAY IN 1b <u>Annapolis Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>47 Larkin Street</u>		1d. STREET ADDRESS <u>47 Larkin Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Scott</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-5-1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Annapolis Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>? Scott</u>		14. MOTHER'S MAIDEN NAME <u>? Boston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Margorie H. Parker 50 Larkin St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chenical Throatitis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-25-58</u> , 19 <u>58</u> , to <u>2-26-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-25-58</u> , 19 <u>58</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u> M.D.		ADDRESS (Street, city or town, state) <u>62 Cothran St, Annapolis Md</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		DATE SIGNED <u>2-26-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-1-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese #108 Wash St Anna Md</u>		24a. REC'D BY REGISTRAR <u>Feb 28 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Allen</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 28 1938

BUREAU V. S.

MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. PLACE OF DEATH	
9. DATE OF DEATH	
10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESS	
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100. SIGNATURE OF DECEASED	

1466

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>H.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>23 CORNHILL ST.</u>				d. STREET ADDRESS <u>123 CORNHILL ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Etta</u> Middle <u>B.</u> Last <u>SHAW</u>				4. DATE OF DEATH Month <u>2</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-19-1884</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>HENRY WEAVER</u>				14. MOTHER'S MAIDEN NAME <u>"UNK"</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>PAUL H. SHAW</u> Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 392X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) <u>UNKNOWN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>17 AN ATION</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>DEC 1954</u> to <u>FEB 1958</u> , that I last saw the deceased alive on <u>6 FEB 1958</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.				ADDRESS (Street, city or town, state) <u>41 Southgate Ave 4/8/58</u> DATE SIGNED <u>4/8/58</u>			
PHYSICIAN'S NAME (Type) <u>Annapolis, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-10-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN</u>		22d. LOCATION (City, town, or county) (State) <u>GLEN BURNIE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Search</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 could be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

6261 01 6261

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1467

## CERTIFICATE OF DEATH

01506

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>67 Collage Ave</u>				d. STREET ADDRESS <u>67 Collage Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Emma Rogers Sherbert</u>				4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-8-1870</u>		9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>A.A.Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Rogers</u>				14. MOTHER'S MAIDEN NAME <u>Violetta Webster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs Louis N. Phipps</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uræmia (Coma)</u> DUE TO (c) <u>General Arterio Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>Several Days</u> <u>Several Yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 10</u> 19 <u>58</u> , to <u>Feb 20</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 20</u> 19 <u>58</u> , and that death occurred at <u>9:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Oliver Purvis</u> M.D.				ADDRESS (Street, city or town, state) <u>Annapolis, Md</u>		DATE SIGNED <u>2/21/58</u>	
PHYSICIAN'S NAME (Type) <u>J. OLIVER PURVIS</u>				<u>40 Franklin St</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-23-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sherbert Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Deale A.A.Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>B 24 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Perkins</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU OF THE ARMY

RECEIVED

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 2 FilmG226 2-28-58 et

01507

## CERTIFICATE OF DEATH

1518

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MARYLAND</u>		COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Glen Burnie</u>				TOWN <u>La Plata</u>		<u>08X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Plaza Manor Conv. Home</u>				STREET ADDRESS (If rural give location) <u>---</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>PETER</u> (Middle) <u>SHORT</u> (Last) <u>SHORT</u>				(Month) <u>2</u> (Day) <u>15</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>C</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b>		<b>9. AGE last birthday</b> <u>88</u> yrs.	<b>IF UNDER 1 YEAR</b> (Months) <u>0</u> (Days) <u>0</u> <b>IF UNDER 24 HRS.</b> (Hours) <u>0</u> (Min.) <u>0</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FARMER</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>LAPLATA CHAS. CO., MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>JIM SHORT</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY SHORT</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b> <u>---</u>		<b>17. INFORMANT &amp; ADDRESS</b>		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>331x IMMEDIATE CAUSE (A)</b> <u>Cerebral - vascular accident</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Arteriole tortuosa general</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Feb 15, 1955</u> , <b>to</b> <u>Feb 15, 1955</u> , <b>that I last saw the deceased alive on</b> <u>Feb 15, 1955</u> , <b>and that death occurred at</b> <u>530</u> M., <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>John T. LEE</u>				<b>DATE SIGNED</b> <u>Feb 15, 1955</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>				<b>DATE THEREOF</b> <u>2-22-58</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>MT. AUBURN</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Charles R. Law</u>				<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>CHARLES R. LAW - 802 MADISON AVE</u>	
<b>DATE</b> <u>FEB 24 1958</u>				<b>ADDRESS</b> (Street, city, town, state) <u>802 Madison Ave</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

BUREAU V. S.

FEB 24 1958

RECEIVED

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased or who has been in attendance at the death. It should be filled out as soon as possible after death, and before the body is moved or buried. It should be filled out in the presence of the family or other persons who may be interested in the death. It should be filled out in the presence of the family or other persons who may be interested in the death. It should be filled out in the presence of the family or other persons who may be interested in the death.

1519

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft George G Meade</b>				c. LENGTH OF STAY IN 1b <b>18hrs 35 min</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Army Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Shotola</b> Last <b>Shotola</b>				4. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>29 Jan 58</b>	
9. AGE (In years last birthday) <b>7</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min. <b>7</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NA</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NA</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Donald Lee Shotola</b>		14. MOTHER'S MAIDEN NAME <b>Rosemaria Theresa Kotecki</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT (Father) <b>Donald Lee Shotola, 800 5th St Laurel, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diffuse pneumonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>492x</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>5</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4 Feb</b> 19 <b>58</b> , to <b>5 Feb</b> 19 <b>58</b> , that I last saw the deceased alive on <b>5 February</b> 19 <b>58</b> , and that death occurred at <b>0530</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5 Feb 58</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Fred M Lafferty</b> M.D.				PHYSICIAN'S NAME (Type) <b>FRED M LAFFERTY CAPT MC</b> <b>US ARMY HOSPITAL, FT MEADE, MD</b>			
22a. BURIAL <b>Burial</b>		22b. DATE THEREOF <b>2/6/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Earl B Wolberton</b> ADDRESS <b>General Home, Inc</b>				24a. REC'D BY REGISTRAR <b>5 Feb 58</b>		24b. REGISTRAR'S SIGNATURE <b>Wilbur H Downson</b>	

2050221xv5 6306-Belair Rd, Baltimore-6, Md

WILBUR H DOWNSON

Journal of Management Education 33(1)

[illegible]

BUREAU V. S.

FEB 10 1953

RECEIVED

James M. Smith



1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01509

1520

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Arnold - R.F.D.</u>		<u>3 weeks</u>		TOWN <u>Arnold - R.F.D.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ruper Manor - Rt 1 - Box 897</u>				STREET ADDRESS (If rural give location) <u>Ruper Manor - Rt 1 - Box 397</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
<u>Robert F. Kessler Specht</u>				<u>Feb 7 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct. 22 - 1878</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Fredricks Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Specht</u>				14. MOTHER'S MAIDEN NAME <u>Arrelia Kessler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Mrs. Ruth Fainall - Same as NO 2</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery Disease</u>						<u>27 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>				21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8-9-</u> , 19 <u>57</u> , to <u>2-7-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-28-</u> , 19 <u>58</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frederic M. Shipley</u>				ADDRESS (Street, city, town, state) <u>M.D. 636119 Ave Annapolis No 2</u>		DATE SIGNED <u>2-10-58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 11 - 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Archie</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
DATE <u>FEB 13 '58</u>							

# CERTIFICATE OF DEATH

1250

File No. 1250

1. DRUGS, REMEDIES, TONICS, OR PREPARATIONS

2. PLACE OF BIRTH

3. OCCUPATION

4. SEX

5. AGE

6. RACE

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF CORONER

16. SIGNATURE OF JURY

17. SIGNATURE OF JUDGE

18. SIGNATURE OF CLERK

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF DEPUTY SHERIFF

21. SIGNATURE OF CONSTABLE

22. SIGNATURE OF ALDERMAN

23. SIGNATURE OF COUNCILMAN

24. SIGNATURE OF SHERIFF

25. SIGNATURE OF DEPUTY SHERIFF

26. SIGNATURE OF WITNESSES

27. SIGNATURE OF CORONER

28. SIGNATURE OF JURY

29. SIGNATURE OF JUDGE

30. SIGNATURE OF CLERK

31. SIGNATURE OF SHERIFF

32. SIGNATURE OF DEPUTY SHERIFF

33. SIGNATURE OF CONSTABLE

34. SIGNATURE OF ALDERMAN

35. SIGNATURE OF COUNCILMAN

36. SIGNATURE OF SHERIFF

37. SIGNATURE OF DEPUTY SHERIFF

38. SIGNATURE OF WITNESSES

39. SIGNATURE OF CORONER

40. SIGNATURE OF JURY

41. SIGNATURE OF JUDGE

42. SIGNATURE OF CLERK

43. SIGNATURE OF SHERIFF

44. SIGNATURE OF DEPUTY SHERIFF

BUREAU V. S.

FEB 13 1939

RECEIVED

SMOOTH SURF

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1521 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01510

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. LENGTH OF STAY IN 1b <u>14 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Severn</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Annapolis &amp; Telegraph Rds.</u>				/d. STREET ADDRESS <u>Annapolis &amp; Telegraph Rds.</u>			
3. NAME OF DECEASED (Type or print) First <u>ALLEN</u> Middle <u>C.</u> Last <u>STEVENSON</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>17</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1897</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>		IF UNDER 24 HRS. Hours <u>    </u> Min. <u>    </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Glen Burnie, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Allen Stevenson</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WW 1</u>		16. SOCIAL SECURITY NO. <u>212 01 4027</u>		17. INFORMANT <u>Mr. Spencer Stevenson,</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>    </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>  <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>    </u> a. m. <u>    </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>		DATE SIGNED <u>2/17/58</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>    </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 21 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1522

CERTIFICATE OF DEATH

01511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>				c. LENGTH OF STAY IN 1b <u>4ys, 2mos, 20ds.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>				e. STREET ADDRESS <u>1011 Spring Street</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edward</u> Last <u>Stokes</u>				4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/7</u>	9. AGE (In years lost birthday) yrs. <u>75?</u>	IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u> Hours <u>19</u> Min. <u>58</u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stevodore</u>			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>
13. FATHER'S NAME <u>James Stokes</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Thomas</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>			16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>Hospital Records</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decubitus Ulcers</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>C. N. S. Syphilis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
Chronic Brain Syndrome associated with Generalized Arteriosclerosis							<input type="checkbox"/> YES <input type="checkbox"/> NO
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----				
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. -----			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 13, 1957</u> to <u>February 24, 1958</u> , that I last saw the deceased alive on <u>February 24, 1958</u> and that death occurred at <u>4:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hildegard Heard Reissmann</u>			ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u>			DATE SIGNED <u>2/25/58</u>	
PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissmann, M. D.</u> <u>Crownsville State Hospital, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-1-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Calvary Cem</u>		22d. LOCATION (City, town, or county) (State) <u>A.A.C. Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rayner Sanders</u>				24a. REC'D BY REGISTRAR <u>Mar 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Quench</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



52

RECEIVED

1523

## CERTIFICATE OF DEATH

01513

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Heights</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4902 Kramme Ave Balto 25</u>				d. STREET ADDRESS <u>1115 Riverside Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>C.</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12 1895</u>	9. AGE (In years last birthday) yrs. <u>62</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Harvey</u>				14. MOTHER'S MAIDEN NAME <u>Laura Ward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>219-30-4602</u>		17. INFORMANT Address <u>Balto 21 Md</u> <u>Mrs. Mary V Michael 11408 Waterford Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinoma</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 14 1958</u> to <u>Feb 14 1958</u> , that I last saw the deceased alive on <u>Feb 14 1958</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Oscar I. Vaskuez M.D.</u>				ADDRESS (Street, city or town, state) <u>1213 Light St. Balto 30 Md</u>		DATE SIGNED <u>2/15/58</u>	
PHYSICIAN'S NAME (Type) <u>Oscar I. Vaskuez</u>				<u>1213 Light St. Balto 30 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mon Feb 18 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn A A CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Howard Evans</u>				ADDRESS <u>1400 S Charles ST</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 18 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>  </u>			

TO HOSPITAL OR TO FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

1468

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Thomas</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>2-</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-18-1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reporter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	
11. BIRTHPLACE (State or foreign country) <u>Davidsonville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Emanuel Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Georganna Tongue</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, none or unknown) <u>No</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>213-36-2401</u>	
17. INFORMANT Address <u>Engenia Thomas Davidsonville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-3-58</u> , 19 <u>58</u> , to <u>2-4-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-4-58</u> , 19 <u>58</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. T. Allen</u> M.D.		DATE SIGNED <u>6-2-58</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		<u>Annapolis Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-9-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Davidsonville Md.</u>
23. BURIAL DIRECTOR'S SIGNATURE <u>William Reese #108 Wash St. Anna Md</u>		24a. REC'D BY REGISTRAR <u>W. T. Allen</u> 24b. REGISTRAR'S SIGNATURE <u>W. T. Allen</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1958

DECEASED'S NAME		DATE OF DEATH	
LAST, FIRST, MIDDLE		MONTH DAY YEAR	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		DATE OF BIRTH	
PLACE OF DEATH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
DISEASE		INJURY	
SYMPTOMS		TREATMENT	
HISTORY		FAMILY HISTORY	
SOCIAL HISTORY		HABITS	
RELIGION		MARRIAGE	
SIGNED AND SWORN TO before me this day of 1958		ATTEST	
Notary Public for Maryland		Notary Public for Maryland	

BUREAU V. S.

FEB 10 1958

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01515

1524

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. LENGTH OF STAY IN 1b <u>4ys, 10mos, 26d.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Zilphy</u> Middle <u>Ellen</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	9. AGE (In years last birthday) yrs. <u>90?</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert Ward</u>		14. MOTHER'S MAIDEN NAME <u>Mervia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular Disease</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Senile Brain Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>-----</u> 19 p. m. <u>-----</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	20f. (City or town) (County) (State) <u>-----</u>
21. I certify that I attended the deceased from <u>November 2, 1956</u> , to <u>February 26, 1958</u> , that I last saw the deceased alive on <u>February 26, 1958</u> , and that death occurred at <u>7:40 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>		ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u>	
DATE SIGNED <u>2/27/58</u>			
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>		<u>Crownsville State Hospital, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>-----</u>	<u>3-6-58</u>	<u>Woodlawn Cem.</u>	<u>Washington DC.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. G. &amp; Co.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '58</u>	
ADDRESS <u>Washington DC</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 6 1958

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ate ath. Page 4

ENDING PHYSICIAN: The law requires that the death certificate be executed within 2.

J b, ne hospital or attending physician.

RECTOR: After this certificate has been signed by the attending physician and completely filled, by the funeral director, page 3 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1469

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>N. H.</i> b. COUNTY <i>Hillsboro</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i> <i>66X-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>115 Victor Parkway</i>		d. STREET ADDRESS <i>461 Belmont St</i>	
3. NAME OF DECEASED (Type or print) <i>Ellen</i> First <i>Martin</i> Middle <i>Thompson</i> Last		4. DATE OF DEATH Month <i>2</i> - Day <i>7</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-27-1885</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Manchester N. H.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>		13. FATHER'S NAME <i>John Martin</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>-</i>	
16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mrs Robert E Sundius</i> Address <i>115 Victor Parkway Annapolis Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO <i>Cardiovascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>-</i> DUE TO (c) <i>-</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Two</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 1 -</i> , 19 <i>58</i> , to <i>Feb 7</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>2/7/58</i> , 19 <i>58</i> , and that death occurred at <i>7:17</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Annapolis Md</i> DATE SIGNED <i>2/7/58</i> ACTUAL SIGNATURE <i>John Heath</i> M.D. <i>Franklin</i> PHYSICIAN'S NAME (Type) <i>E. Heath</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-7-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Joseph's Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Manchester N. H.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Saylor</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 10 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Albee</i>

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1525

CERTIFICATE OF DEATH

Reg. Dist. No.

01517

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Park</b>				c. LENGTH OF STAY IN 1b <b>30yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>108 Seventh Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Tomally Tobiason Thompson</b>				4. DATE OF DEATH <b>February 21 1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 7, 1881</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Norway</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>				13. FATHER'S NAME <b>Jacob Tobiason</b>			
14. MOTHER'S MAIDEN NAME <b>Anna Nielson</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <b>Miss Judith Thompson 108 Seventh Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery disease</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of uterus &amp; metastases</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>1/1 1957</b> to <b>2/20 1958</b> , that I last saw the deceased alive on <b>2/21 1958</b> , and that death occurred at <b>7 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5010A Ritchie Highway</b> DATE SIGNED ACTUAL SIGNATURE <b>Morton M. Gieger</b> M.D. PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>Feb. 24, 1958</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b> 22d. LOCATION (City, town, or county) (State) <b>Ritchie Hwy., A. A. CO. Md.</b> 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>George J. Bone 4001 Ritchie Hwy.</b> 24a. REC'D BY REGISTRAR DATE <b>FEB 25 '58</b> 24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**BUREAU V. S.**

FEB 23 1958

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 01518

1526

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>10 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>319 6th. Ave., N.E.</u>				d. STREET ADDRESS <u>319 6th. Ave., N.E.</u>			
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>C.</u> Last <u>VOGEL, SR.</u>				4. DATE OF DEATH Month <u>February</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 26, 1869</u>	
9. AGE (In years lost birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber (ret)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Charles Vogel</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mrs. Minnie Buchta</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>1952</u> , 19 <u>  </u> , to <u>Feb. 16, 1958</u> , that I last saw the deceased alive on <u>Feb. 14, 1958</u> , and that death occurred at <u>10:45 M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>  </u>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D. <u>  </u>							
PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> <u>Glen Burnie, Maryland</u> <u>2/16/58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schimunek</u>				24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
ADDRESS <u>3331 Brehms Lane</u>				DATE <u>FEB 20 '58</u>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. SIGNATURE OF PHYSICIAN [Illegible]	
10. SIGNATURE OF REGISTRAR [Illegible]		11. SIGNATURE OF WITNESS [Illegible]		12. SIGNATURE OF DECEASED [Illegible]	
13. SIGNATURE OF DECEASED [Illegible]		14. SIGNATURE OF DECEASED [Illegible]		15. SIGNATURE OF DECEASED [Illegible]	
16. SIGNATURE OF DECEASED [Illegible]		17. SIGNATURE OF DECEASED [Illegible]		18. SIGNATURE OF DECEASED [Illegible]	
19. SIGNATURE OF DECEASED [Illegible]		20. SIGNATURE OF DECEASED [Illegible]		21. SIGNATURE OF DECEASED [Illegible]	
22. SIGNATURE OF DECEASED [Illegible]		23. SIGNATURE OF DECEASED [Illegible]		24. SIGNATURE OF DECEASED [Illegible]	
25. SIGNATURE OF DECEASED [Illegible]		26. SIGNATURE OF DECEASED [Illegible]		27. SIGNATURE OF DECEASED [Illegible]	
28. SIGNATURE OF DECEASED [Illegible]		29. SIGNATURE OF DECEASED [Illegible]		30. SIGNATURE OF DECEASED [Illegible]	
31. SIGNATURE OF DECEASED [Illegible]		32. SIGNATURE OF DECEASED [Illegible]		33. SIGNATURE OF DECEASED [Illegible]	
34. SIGNATURE OF DECEASED [Illegible]		35. SIGNATURE OF DECEASED [Illegible]		36. SIGNATURE OF DECEASED [Illegible]	
37. SIGNATURE OF DECEASED [Illegible]		38. SIGNATURE OF DECEASED [Illegible]		39. SIGNATURE OF DECEASED [Illegible]	
40. SIGNATURE OF DECEASED [Illegible]		41. SIGNATURE OF DECEASED [Illegible]		42. SIGNATURE OF DECEASED [Illegible]	
43. SIGNATURE OF DECEASED [Illegible]		44. SIGNATURE OF DECEASED [Illegible]		45. SIGNATURE OF DECEASED [Illegible]	
46. SIGNATURE OF DECEASED [Illegible]		47. SIGNATURE OF DECEASED [Illegible]		48. SIGNATURE OF DECEASED [Illegible]	
49. SIGNATURE OF DECEASED [Illegible]		50. SIGNATURE OF DECEASED [Illegible]		51. SIGNATURE OF DECEASED [Illegible]	
52. SIGNATURE OF DECEASED [Illegible]		53. SIGNATURE OF DECEASED [Illegible]		54. SIGNATURE OF DECEASED [Illegible]	
55. SIGNATURE OF DECEASED [Illegible]		56. SIGNATURE OF DECEASED [Illegible]		57. SIGNATURE OF DECEASED [Illegible]	
58. SIGNATURE OF DECEASED [Illegible]		59. SIGNATURE OF DECEASED [Illegible]		60. SIGNATURE OF DECEASED [Illegible]	
61. SIGNATURE OF DECEASED [Illegible]		62. SIGNATURE OF DECEASED [Illegible]		63. SIGNATURE OF DECEASED [Illegible]	
64. SIGNATURE OF DECEASED [Illegible]		65. SIGNATURE OF DECEASED [Illegible]		66. SIGNATURE OF DECEASED [Illegible]	
67. SIGNATURE OF DECEASED [Illegible]		68. SIGNATURE OF DECEASED [Illegible]		69. SIGNATURE OF DECEASED [Illegible]	
70. SIGNATURE OF DECEASED [Illegible]		71. SIGNATURE OF DECEASED [Illegible]		72. SIGNATURE OF DECEASED [Illegible]	
73. SIGNATURE OF DECEASED [Illegible]		74. SIGNATURE OF DECEASED [Illegible]		75. SIGNATURE OF DECEASED [Illegible]	
76. SIGNATURE OF DECEASED [Illegible]		77. SIGNATURE OF DECEASED [Illegible]		78. SIGNATURE OF DECEASED [Illegible]	
79. SIGNATURE OF DECEASED [Illegible]		80. SIGNATURE OF DECEASED [Illegible]		81. SIGNATURE OF DECEASED [Illegible]	
82. SIGNATURE OF DECEASED [Illegible]		83. SIGNATURE OF DECEASED [Illegible]		84. SIGNATURE OF DECEASED [Illegible]	
85. SIGNATURE OF DECEASED [Illegible]		86. SIGNATURE OF DECEASED [Illegible]		87. SIGNATURE OF DECEASED [Illegible]	
88. SIGNATURE OF DECEASED [Illegible]		89. SIGNATURE OF DECEASED [Illegible]		90. SIGNATURE OF DECEASED [Illegible]	
91. SIGNATURE OF DECEASED [Illegible]		92. SIGNATURE OF DECEASED [Illegible]		93. SIGNATURE OF DECEASED [Illegible]	
94. SIGNATURE OF DECEASED [Illegible]		95. SIGNATURE OF DECEASED [Illegible]		96. SIGNATURE OF DECEASED [Illegible]	
97. SIGNATURE OF DECEASED [Illegible]		98. SIGNATURE OF DECEASED [Illegible]		99. SIGNATURE OF DECEASED [Illegible]	
100. SIGNATURE OF DECEASED [Illegible]		101. SIGNATURE OF DECEASED [Illegible]		102. SIGNATURE OF DECEASED [Illegible]	

BUREAU Y. 3

FEB 20 1938

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1527

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Pasadena</u>		c. LENGTH OF STAY IN lb <u>8 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 9 Box 100</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen Wells</u>		4. DATE OF DEATH <u>February 1st.</u> 19 <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/8/11</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Hancock County, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Williams</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Lane</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Theophilus Wells (husband)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Asthenia due to mental troubles.</u> <u>790.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Due to mental troubles deceased would go days and months without food.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/1/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 4-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. D. Singleton</u>		24a. REC'D BY REGISTRAR <u>FEB 1 8 58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>W. D. Singleton</u>	

RECEIVED

FEB 18 1933

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1470

## CERTIFICATE OF DEATH

01520

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Marie</b> Last <b>Wells</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>8</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 16, 1902</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory Worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>George Harvey</b>				14. MOTHER'S MAIDEN NAME <b>Lucretia Fields</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				17. INFORMANT <b>Robert Harvey</b> Address <b>9 Gardiner Pl. Montclair, N.J.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RENAL INSUFFICIENCY</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE + ARTERIOSCLEROTIC</b> DUE TO (c) <b>CARDIOVASCULAR RENAL DISEASE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>2/5</b> , 19 <b>58</b> , to <b>2/8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/7</b> , 19 <b>58</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard N. Peeler</b> M.D.				ADDRESS (Street, city or town, state) <b>68 FRANKLIN ST. ANNAPOLIS, MD</b>			
DATE SIGNED <b>2/8/58</b>				PHYSICIAN'S NAME (Type) <b>RICHARD N. PEELER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 11, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>St. Michaels Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Norman D. Marshall</b>				ADDRESS <b>St. Michaels</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 11 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]		7. MARITAL STATUS [REDACTED]		8. COLOR [REDACTED]	
9. DATE OF DEATH [REDACTED]		10. TIME OF DEATH [REDACTED]		11. PLACE OF DEATH [REDACTED]		12. CAUSE OF DEATH [REDACTED]	
13. MEDICAL EXAMINER'S SIGNATURE [REDACTED]		14. PHYSICIAN'S SIGNATURE [REDACTED]		15. CORONER'S SIGNATURE [REDACTED]		16. COUNTY CLERK'S SIGNATURE [REDACTED]	
17. COUNTY OF DEATH [REDACTED]		18. CITY OF DEATH [REDACTED]		19. STATE OF DEATH [REDACTED]		20. ZIP CODE [REDACTED]	
21. DATE OF INTERVIEW [REDACTED]		22. TIME OF INTERVIEW [REDACTED]		23. PLACE OF INTERVIEW [REDACTED]		24. NAME OF INTERVIEWER [REDACTED]	
25. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		26. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		27. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		28. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
29. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		30. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		31. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		32. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
33. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		34. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		35. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		36. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
37. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		38. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		39. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		40. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
41. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		42. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		43. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		44. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
45. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		46. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		47. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		48. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
49. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		50. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		51. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		52. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
53. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		54. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		55. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		56. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
57. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		58. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		59. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		60. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
61. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		62. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		63. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		64. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
65. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		66. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		67. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		68. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
69. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		70. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		71. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		72. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
73. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		74. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		75. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		76. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
77. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		78. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		79. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		80. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
81. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		82. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		83. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		84. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
85. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		86. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		87. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		88. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
89. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		90. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		91. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		92. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
93. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		94. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		95. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		96. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	
97. NAME OF DECEASED'S NEXT OF KIN [REDACTED]		98. ADDRESS OF DECEASED'S NEXT OF KIN [REDACTED]		99. CITY OF DECEASED'S NEXT OF KIN [REDACTED]		100. STATE OF DECEASED'S NEXT OF KIN [REDACTED]	

BUREAU V. 1

FEB 11 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

01521

1528

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft George G. Meade</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G Meade</b> d. STREET ADDRESS <b>Quarters 4541, English Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>M</b> Last <b>WILLARD</b>		4. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Can</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 February 1880</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR: Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (State or foreign country) <b>Vermont</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown Frank Prevast</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Agnes Sawyer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Son: Paul S. Willard</b>		Address <b>Quarters 4541, English Avenue, Fort George G Meade, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular Thrombosis</b> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebro-vascular Thrombosis</b> DUE TO (c) <b>20 days</b> INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>16 Jan., 1958</b> , to <b>5 Feb.</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5 Feb.</b> , 19 <b>58</b> , and that death occurred at <b>3:25 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. ARMY HOSPITAL, FT MEADE, MD 5 Feb 58</b>			
ACTUAL SIGNATURE <b>John L. Robertson</b>		M.D. <b>U. S. ARMY HOSPITAL, FT MEADE, MD</b>	
PHYSICIAN'S NAME (Type) <b>JOHN L. ROBERTSON, CAPT, MC</b>		<b>U.S. ARMY HOSPITAL, FT MEADE, MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>2/7/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Calman Manor, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>He Witt Cavallan</b>		ADDRESS <b>Calman Manor, Md</b>	
24a. REC'D BY REGISTRAR <b>5 Feb 58</b>		24b. REGISTRAR'S SIGNATURE <b>Wilbur H. Downs, Jr.</b>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

FEB 10 1953

RECEIVED

1875

CERTIFICATE OF DEATH

Reg. Dist. No.

01522

1. PLACE OF DEATH a. COUNTY <b>ANNIE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>A.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARLEY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARLEY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1. d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>AGATHA L. WILLIAMS</b>		4. DATE OF DEATH Month Day Year <b>FEB 17 1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>COLOR</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>JAN 28, 1957</b>
9. AGE (In years, months, days, hours, min.) <b>21</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>JACOBESVILLE, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>JOSEPH BAKER</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA SMITH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>MRS LOLA HINES</b>		Address <b>207 CEDAR HILL LANE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute pulmonary edema</b> DUE TO <b>Cardiac decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <b>Arteriosclerotic cardiovascular disease</b> (b) <b>Arteriosclerotic cardiovascular disease</b> (c) <b>Arteriosclerotic cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>3 months</b> <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x diabetes mellitus, mild</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 13, 1957</b> , to <b>Feb 17, 1958</b> , that I last saw the deceased alive on <b>Feb 14, 1958</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R.M. McLaughlin</b> M.D.		ADDRESS (Street, city or town, state) <b>Pasadena, Md.</b> DATE SIGNED <b>Feb 18, 1958</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>FEB 21 '58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MTCAL CEM</b>		22d. LOCATION (City, town, or county) (State) <b>BROOKLAND A.A.C.O MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ELROY D WILSON</b>		ADDRESS <b>1000 BRANTLEY AVE</b>	
24. REC'D BY REGISTRAR <b>FEB 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR A PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**BUREAU V. S.**

FEB 27 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1530

## CERTIFICATE OF DEATH

01523

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>				c. LENGTH OF STAY IN 1b <u>5mos. 2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>				d. STREET ADDRESS <u>1315 Spring Street</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>R.</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE (In years lost birthday) <u>80?</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) _____	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Hospital Records</u> Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____				20g. (County) _____		20h. (State) _____	
21. I certify that I attended the deceased from <u>August 24</u> , 19 <u>57</u> , to <u>February 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>February 22</u> , 19 <u>58</u> , and that death occurred at <u>2:45 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Ludwig Benedict</u> M.D. <u>Crownsville, Md.</u> <u>2/25/58</u> PHYSICIAN'S NAME (Type) <u>Ludwig Benedict, M. D.</u> <u>Crownsville State Hospital, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>2-28-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>	
22d. LOCATION (City, town, or county) <u>Cedar Hill Md.</u>				22e. (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Adolphus Halstead</u>				ADDRESS <u>918 Walnut Hill</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 27 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF OTHERS	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN		21. SIGNATURE OF OTHERS	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF NEXT OF KIN		24. SIGNATURE OF OTHERS	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF OTHERS	
28. SIGNATURE OF DECEASED		29. SIGNATURE OF NEXT OF KIN		30. SIGNATURE OF OTHERS	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF NEXT OF KIN		33. SIGNATURE OF OTHERS	
34. SIGNATURE OF DECEASED		35. SIGNATURE OF NEXT OF KIN		36. SIGNATURE OF OTHERS	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF NEXT OF KIN		39. SIGNATURE OF OTHERS	
40. SIGNATURE OF DECEASED		41. SIGNATURE OF NEXT OF KIN		42. SIGNATURE OF OTHERS	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF NEXT OF KIN		45. SIGNATURE OF OTHERS	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF NEXT OF KIN		48. SIGNATURE OF OTHERS	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF NEXT OF KIN		51. SIGNATURE OF OTHERS	
52. SIGNATURE OF DECEASED		53. SIGNATURE OF NEXT OF KIN		54. SIGNATURE OF OTHERS	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF NEXT OF KIN		57. SIGNATURE OF OTHERS	
58. SIGNATURE OF DECEASED		59. SIGNATURE OF NEXT OF KIN		60. SIGNATURE OF OTHERS	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF OTHERS	
64. SIGNATURE OF DECEASED		65. SIGNATURE OF NEXT OF KIN		66. SIGNATURE OF OTHERS	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF NEXT OF KIN		69. SIGNATURE OF OTHERS	
70. SIGNATURE OF DECEASED		71. SIGNATURE OF NEXT OF KIN		72. SIGNATURE OF OTHERS	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF NEXT OF KIN		75. SIGNATURE OF OTHERS	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF NEXT OF KIN		78. SIGNATURE OF OTHERS	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF NEXT OF KIN		81. SIGNATURE OF OTHERS	
82. SIGNATURE OF DECEASED		83. SIGNATURE OF NEXT OF KIN		84. SIGNATURE OF OTHERS	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF NEXT OF KIN		87. SIGNATURE OF OTHERS	
88. SIGNATURE OF DECEASED		89. SIGNATURE OF NEXT OF KIN		90. SIGNATURE OF OTHERS	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF NEXT OF KIN		93. SIGNATURE OF OTHERS	
94. SIGNATURE OF DECEASED		95. SIGNATURE OF NEXT OF KIN		96. SIGNATURE OF OTHERS	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF NEXT OF KIN		99. SIGNATURE OF OTHERS	
100. SIGNATURE OF DECEASED		101. SIGNATURE OF NEXT OF KIN		102. SIGNATURE OF OTHERS	

BUREAU V. 3

FEB 27 1958

RECEIVED

1471  
CERTIFICATE OF DEATH

Reg. Dist. No. 01524

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>U.</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
13. FATHER'S NAME <u>Richard Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Emily Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Altie Harris</u>		Address <u>15 Junius Ave. Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aneurysm of aorta erosion into</u> <u>022X</u> DUE TO <u>Freachee giving pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Syphilis</u> DUE TO <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 Wk.</u> <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>
21. I certify that I attended the deceased from <u>1-10-58</u> 19 <u>  </u> to <u>2-11-58</u> 19 <u>  </u> , that I last saw the deceased alive on <u>2-11-58</u> 19 <u>  </u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u>		ADDRESS (Street, city or town, state) <u>63 College Ave</u> DATE SIGNED <u>2-14-58</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		<u>Annapolis Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Montgomery Chapel</u>	22d. LOCATION (City, town, or county) <u>Hyattsville Maryland</u> (State) <u>  </u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keese</u>		ADDRESS <u>108 Wash. St. Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

CERTIFICATE OF DEATH

1938

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF CORONER		14. SIGNATURE OF JURY		15. SIGNATURE OF WITNESSES		16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL		19. SIGNATURE OF CREMATION		20. SIGNATURE OF OTHER	

**RECEIVED**  
 FEB 27 1938  
 BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 1525

1531

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Elvaton MD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Peter F. Zeman</u>		4. DATE OF DEATH <u>2-5-58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Monitor Computer Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John Zeman</u>	
14. MOTHER'S MAIDEN NAME <u>Marie (Unknown)</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>215-09-5927</u>		17. INFORMANT <u>Son, Stephen F. Zeman</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Generalized Arteriosclerosis</u> DUE TO <u>Optic Atrophy (bilateral)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>58</u> , to <u>1958</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 12</u> , 19 <u>57</u> ; and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. HAHN</u>		ADDRESS (Street, city or town, state) <u>Severna Park Md 21558</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		DATE SIGNED <u>2-5-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/8/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Singletary</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. FEE'D BY REGISTRAR <u>W. J. S. S. S.</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. S. S. S.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR TO FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

